Sustaining and managing the delivery of student nurse mentorship:

Roles, resources, standards and debates

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Glossary of terms/abbreviations

CPC: Clinical Placement Coordinator
CPM: Clinical Placement Managers
CPF: Clinical Placement Facilitator
CRB: Criminal Records Bureau
DH: Department of Health
ENB: English National Board
ESR: electronic staff records
HEI: Higher Education Institution
IRAS: Integrated Research Application System
ITU: Intensive Care Unit
MMP: Measuring Mentor Potential
NMC: Nursing and Midwifery Council of the UK
OH: Occupational Health
PDF: Practice Development Facilitator
PEF: Practice Education Facilitators
QAA: Quality Assurance Agency
WDC: Workforce Development Confederation
Executive summary

Context and purpose
The extent to which newly qualified nurses are adequately prepared for the responsibilities of their first post is a key concern for prospective employers and for the service and education staff charged with responsibility for student nurse education. One of the major components of student nurse preparation is mentorship – the process by which a student nurse (mentee) during periods of practical experience (placements) is attached to a qualified nurse (mentor) who guides the student’s practice, assesses their progress and judges their competence as fit to be placed on the Nursing and Midwifery Council (NMC) register of nurses. Mentorship has long been regarded as the cornerstone of nurse education and, as such, the experience of both mentor and mentee has been the focus of a considerable volume of research.

The delivery and receipt of mentorship, however, is situated within a complex set of roles and multi-stranded relationships between diverse personnel in higher education institutions (HEIs) and the service providers with whom they link for purposes of nurse education. Enabling mentorship to be delivered entails a range of resources and activities which are subject to a diversity of contextual influences; in particular the economic and professional factors affecting higher education and healthcare and a range of quality assurance frameworks including the standards for mentorship set by the NMC. Moreover, the nature of mentorship and the way in which it might best develop in the future are the subject of ongoing debate. This ‘hinterland’ to the delivery of mentorship has been the subject of much less research than the experiences of mentors and mentees and yet it is this hinterland that enables delivery to take place.

This executive summary reports on a project that aimed to investigate this ‘hinterland’ in relation to capacity for the delivery of mentorship and to do so from the perspective of staff involved in its provision in higher education and service. The project was one of four funded by NHS London as part of their ‘Readiness for Work’ programme; it was initiated as a collaborative venture between the National Nursing Research Unit (NNRU) of King’s College London and Chelsea and Westminster Hospital NHS Foundation Trust and led by Dr Sarah Robinson of the NNRU as principal investigator.

Objectives and methods
The aim of the project was addressed through three objectives, each focusing on an aspect of capacity:

- Capacity in relation to providing sufficient numbers of placements, mentors and sign-off mentors to match student numbers;
- Capacity in terms of delivering educational preparation to enable mentors and sign-off mentors to fulfil their roles;
- Capacity in relation to factors influencing delivery in practice.

Joint HEI and service responsibility for mentorship was reflected in the project design. Two London-based HEIs were selected that together represented diversity in relation to geographical location, approach to teaching the mentorship course, and specific posts with a remit for mentorship. For
each HEI, a sample was selected of the trusts with which they linked that ensured a spread across hospital, mental health and primary care trusts and a diversity of adult, child and mental health practice settings.

Semi-structured interviews were held in 2011 with 37 personnel (22 from the two HEIs and 15 from the seven trusts) purposively selected to represent key roles in the provision of mentorship. In the HEIs, these included senior educationalists whose brief included a remit for mentorship, programme directors, placement allocation officers, mentorship programme leaders, and lecturers with a link to practice (in one HEI, the group of link lecturers included those holding a new post of learning community education advisor). Personnel in the trusts included senior educationalists whose brief included a remit for mentorship and practice education facilitators (PEFs); mentors themselves were not included. Interviewees did not include those working in the independent sector; however some of the lecturers linked with this sector.

The synthesised interview data enabled analysis of the range of experiences and perceptions for each of the processes entailed in each objective, the different positions adopted for aspects of mentorship that were the subject of debate, and associations between these and different groups of post-holders within and between the HEIs and trusts. Findings are presented as achievements in enabling mentorship to be delivered; the challenges that these achievements presented, and debates about the future shape and resourcing of mentorship.

**Mentorship capacity: achieving remits to enable mentorship to be delivered**

HEI and trust participants, in the main, reported fulfilling their remits for enabling mentorship to be delivered; these are summarised here in relation to each aspect of capacity addressed in the project objectives, perceptions of factors enabling remits to be fulfilled, and the outcomes of mentorship in practice.

**Providing mentors and sign-off mentors:** Availability and ratio of mentors to students are key criteria for practice areas to be considered as suitable learning environments for students, as is the availability of sign-off mentors in final destination placements.

Ensuring that there were sufficient numbers of mentors entailed assessing the number needed on the basis of information contained in the register of mentors and placement audits and on the basis of local knowledge of practice areas by PEFs and link lecturers. Deciding which staff should attend the course was usually made on the basis of appraisals; trust senior educationalists then commissioned places on the HEI mentorship course.

The introduction of sign-off mentorship was regarded by most participants as raising awareness of professional accountability for making judgements about student competence and locating such decisions with experienced practitioners. Introducing sign-off mentorship was a resource intensive activity with PEFs and link lecturers providing practice staff with information about what it would entail, running study days and workshops for trainee sign-off mentors, and organising the simulated and/or in practice observed assessments of competence.

**Providing placements and allocating students:** Ensuring that suitable learning environments are available within which students can gain requisite practical experience for their course is a major
component of mentorship capacity. Finding placements depended on detailed knowledge of local services and was a major pre-occupation for HEI personnel who were constantly looking out for new areas to develop. PEFs likewise were alert to how new services could offer practical experience for students. Auditing suitability of new areas entailed a substantial amount of work. Allocating cohorts of students to placements was a complex undertaking informed by local knowledge of practice settings; it was centralised in one HEI but less so in the other. Decisions about the number of students each setting could support were made jointly between HEI and trust personnel with agreement, by and large, that the final decision should rest with service staff. In most instances, decisions about allocating students to individual mentors was made by the managers of practice settings although the decision could be informed by knowledge of the student held by the PEF and/or the link lecturer.

Much effort was expended in sustaining and enhancing placement capacity: innovative strategies to bring a wider range of community settings into the placement circuit than hitherto; encouraging specialist areas to accept students; encouraging staff to become mentors and finding them places on the course at short notice; preserving existing placements by maximising support for areas revealed as struggling; supporting staff in the independent sector in becoming mentors; and introducing new models of placement provision.

**Educational preparation of mentors:** Capacity to deliver high quality mentorship also depends on the educational preparation of mentors. Both HEIs provided preparation for mentors by means of a course perceived as being good or adequate. The course, based on the 8 NMC domains for learning and assessing, was offered in on-line and blended learning formats, with a membership drawn from all branches. Mentoring activities undertaken by learner mentors in practice were supervised by a ‘mentor buddy’ and the course as a whole was assessed by a series of written assignments. Additional support was provided by course teachers, particularly for those who needed help with study skills and academic writing. The course was regarded as challenging to teach and support was provided in the form of: induction programmes for newly appointed teachers, ongoing support for the whole team and support for the mentorship programme leaders.

**Delivery in practice:** To facilitate students gaining maximum benefit from their course, trust and HEI participants provided them with induction programmes prior to initial and subsequent placements. Part of the role of PEFs and link lecturers was managing student expectations of placements. The majority of participants perceived that the NMC standard of students spending 40% of their time working with the mentor (or other appropriate staff) was met for most students. This was achieved with difficulty in some of the very busy practice settings and could depend on mentors using their own time to fulfil all the requirements of their mentoring role. Meeting the standard of sign-off mentors having one hour a week protected time to spend with final destination placement students was more challenging and could also depend on staff using their own time, particularly in acute settings in adult and mental health services.

PEFs and link lecturers supported mentors through a range of electronic means and in face-to-face meetings in the course of drop-in fora, during the course of a regular visit to the area, or as a pre-arranged meeting on site. High visibility of PEFs and link lecturers was perceived as facilitating the ease with which mentors felt able to raise problems and they were encouraged to seek advice as
soon as a problem arose. The NMC requirement for mentors to have an annual update was met in diverse ways: inclusion as a session in a trust-based mandatory training programme; as a stand-alone half-day or full-day workshop, and opportunistically in practice settings in the course of a visit by the PEF and/or link lecturer, sometimes for a small group and sometimes on a one-to-one basis. These updates were provided by PEFs alone, by link lecturers alone, and jointly; the balance of relative participation differed by trust. Triennial reviews were at an early stage of implementation at the time of fieldwork and were usually undertaken in the course of annual appraisals; preliminary observations were made that these reviews were a valuable means of professional development and a measure of mentorship capacity.

The quality of mentorship delivery was monitored through several mechanisms: the NMC-required placement audits; student evaluations of each of their placements, and ongoing feedback from PEFs and link lecturers. There was considerable variation in reported involvement of trust and HEI personnel in the placement audits but they were generally regarded as a shared responsibility.

**Enabling remits for mentorship to be met.** Fulfilling remits for mentorship depended on partnership working and a range of resources in terms of funding and time.

**Partnership working:** The hallmark of partnership working were multi-stranded working relationships between diverse personnel, channels for regular communication between all parties, and ongoing negotiations about capacity to fulfil their remits. Liaison between senior trust and HEI personnel enabled swift response to changing needs for course places and ensured that all commissioned places were taken up. The working relationship between link lecturers and PEFs and between these personnel and practice staff were regarded as central to enabling mentorship to be delivered. These relationships were the ‘glue’ that held the system together and were characterised by: detailed knowledge of practice settings and circumstances; flexibility in meeting changing circumstances, particularly over the number of students who could be supported; creativity in enhancing placement capacity, and through developing materials to support mentors, supervising mentors, sign-off mentors and mentorship course teachers.

**Resources:** In HEIs and trusts, a considerable amount of resource was expended in funding and staff time in developing websites and materials to support the different stages of mentorship from taking the course through to triennial reviews, with the aim of providing timely information for staff and students and in clarifying, standardising and streamlining the various documents. Diverse meetings were held to discuss, plan and make decisions about providing mentorship and ensuring its quality; these included: formal committees for all those in the HEIs and healthcare providers involved in mentorship; specific groups such as PEFs, and meetings for personnel involved with a specific practice area.

Knowledge of the cost of the mentorship course for trusts was, in the main, uncertain and inconsistent; figures provided indicated a range between £49,500 and £71,500 per annum. Availability of study leave to attend the course varied within and between trusts as did the extent to which this was covered in practice setting budgets. A major resource was the time necessitated in all the processes and activities entailed in enabling mentorship to be delivered and in building and sustaining good working relationships. Resourcing mentorship also included the time and expertise...
of ‘mentor buddies’ who supervised learner mentors and the sign-off mentors who assessed the trainee sign-off mentor’s ability to assess student competence.

**Outcomes:** Mentorship was perceived as making a positive contribution to student preparation and competence, with observations by some that there was no unequivocal evidence to this effect. By and large, mentors were perceived as ‘doing a good job’, often in challenging circumstances, and that as much as possible has been put in place to ensure that mentors and sign-off mentors could fulfil their remit.

**Mentorship capacity: Challenges in sustaining and managing mentorship**

Considerable achievements were perceived in enabling mentorship to be delivered. At the same time, throughout participants’ accounts there was a sense of the system just holding together and that it was under considerable pressure and facing a diverse range of challenges.

**Changing environments:** Changes in existing links between HEIs and trusts, through trust mergers and changes in nurse education contracts, offered new opportunities but also the potential to disrupt long-established and productive relationships (e.g. groups who had been working together to standardise a set of assessment documents). Placement provision and the number of students who could be supported were under pressure from: reconfiguration of services; reduction in numbers of qualified nurses, and teams being broken up and reconstituted with different profiles. The use of the independent sector for student experience was growing and welcomed but required high levels of support from HEI staff.

**Responsibilities of HEI and trust staff and costing of time:** Although partnership working was on the whole positive, there was not always unanimity over whether responsibility for particular aspects of provision was shared, the responsibility of the HEI or that of the trust. As staff came under increased pressure and NMC requirements became more demanding, this lack of clarity was seen to be more of a problem than hitherto. Trust participants, in particular, were concerned that meeting some of the NMC requirements, such as the one hour a week protected time for sign-off mentors had not been costed into trust budgets and that these were partly met by staff using their own time, particularly in busy, acute settings.

**Practice education posts:** Conflicting demands on time were becoming increasingly acute for link lecturers and both they and trust colleagues regretted the reduction in time that some were able to spend in practice settings. Senior HEI educationalists thought that the link lecturer system was no longer sustainable in its present format and that different approaches were needed. One of the HEIs had responded to the need for a consistent HEI presence in practice with the introduction of learning community education advisor posts; however, sustained funding for these posts was not guaranteed. The role of the practice education facilitator (PEF) had been introduced to strengthen and develop support for practice education and was perceived as central to enabling mentorship to be delivered; however, the breadth of their role was challenging and there were concerns about sustained funding for these posts.

**Educating mentors:** Educational preparation presented a range of challenges. Meeting the needs of learner mentors with very diverse academic backgrounds required additional support from course teachers and raised questions about whether the course was offered at an appropriate level for staff.
in all settings in which practical experience was required for students. Managing anxieties about the assessment component of the mentor’s role was challenging and necessitated achieving a balance between ensuring learner mentors were aware of the responsibilities and accountability that this entailed and, at the same time, developing their confidence in being able to make judgements about competence. There were concerns over trusts giving learner mentors the NMC requisite study leave and, in particular, that leave was not always perceived by trusts as being necessary for on-line sessions on the course. The increasing move to on-line provision of courses and annual updates was seen as appropriate for providing information but was a challenging format in which to hold discussions about difficult aspects of mentoring such as managing the failing student.

**Student numbers matching placement capacity:** Some senior trust and HEI staff regarded the commissioning process as creating difficulties from the outset over the sources of information upon which it was based and that this then required protracted negotiations between trust and HEI personnel at all levels as to how all students could be provided with the requisite practical experience for their course. Difficulties in placing students were more marked in adult and children’s services than in mental health services.

**Meeting quality assurance standards:** Ensuring the quality of mentorship provision ran through participants’ account of their responsibilities and activities and these entailed multiple mechanisms and safeguards to ensure adherence to NMC standards for mentorship. At the same time, meeting these standards was perceived as presenting challenges and these included: time required for implementation not having been built into trust budgets; insufficient liaison between the NMC and trusts over the implications of implementation; considerable time and effort was required to ensure that personnel were informed of the implications of new standards and regular revisions to existing standards; some standards were regarded as being unclear as to exactly what was required; and the NMC holding HEIs responsible for ensuring that standards had been met when responsibility for meeting the standards was perceived as lying with the trusts.

**Assessment measures in practice:** The governance of procedures to assess students in practice was seen by some HEI and trust participants as less robust than those in higher education where there was a long-established system of several people assessing work through marking, moderating, external examining and assessment boards. The challenge was to have a similarly robust system of assessment in clinical practice where at present decisions were made by a single person: the mentor assessing the student; the sign-off mentor assessing the final destination placement student; the supervising mentor assessing the learner mentor; and the qualified sign-off mentor assessing the trainee sign-off mentor.

**Mentorship capacity: debating future directions**
The challenges with which the delivery of mentorship was confronted, together with a rapidly changing financial, professional and organisational climate and some participants’ views that it was time to rethink the way in which mentorship is provided, led to the identification of various debates about its resourcing and future structure. The project did not set out to recommend one course of action rather than another but rather to delineate participants’ perceptions of their implications.
Future directions for the shape of mentorship and practical experience:

Very diverse views were held as to whether all nurses should be mentors (the generic position) or whether mentorship should be developed as a specialist career pathway (the specialist position). Both views were represented among trust participants, with most senior educationalists preferring the generic position and most PEFs the specialist. Likewise both views were represented among the HEI participants, with senior educationalists and mentorship programme leaders preferring the specialist position and the programme directors and link lecturers divided over this issue.

Those favouring the generic position saw mentoring as an integral part of the role of all nurses, that is was the only way of providing enough mentors for the numbers of students, and that the introduction of sign-off mentors had addressed the problem of final assessments being made by someone with experience.

Those favouring the specialist position thought that people could be excellent nurses without the aptitude or desire to be mentors, that substantial experience was needed to make assessments of students, and that it would be preferable to have fewer experienced people with dedicated time built into their roles to be making these assessments. The specialist position would mean breaking the link between the mentorship qualification being required for promotion but would offer a specialist career pathway of mentors and senior mentors for those who wanted to specialise in nurse education.

The generic/specialist debate was linked to debates about the future shape of practical experience. Concerns were expressed by some that placements were too short for mentors to be able to know students well enough to make judgements about their competence. Various other models of placements and mentoring were described that had been implemented in a few settings. These included: client attachment in mental health settings (students attached to a client and then mentored by staff in settings along the client’s care pathway) and hub and spoke (students based in a hub e.g. a health centre but also spending time in spokes which were practice settings associated with the hub). The latter model was described as being able to fit with new models of mentoring in which a senior mentor in the hub took overall responsibility for the students and their assessment and mentors in the spokes reported to the senior mentor on the students’ progress. Diverse views and experiences emerged as to how and whether these models might work in different practice settings.

These various positions raised a series of linked questions:

- Is the education of student nurses best served by a system in which all nurses are mentors or should the role be taken up as a discrete career pathway by fewer nurses who have more dedicated time to spend with students?
- Can the mentoring needs of the numbers of students in practice settings be met by fewer mentors each spending more time with students?
- How might the different approaches that have been advocated mesh with diverse practice settings and services and with the independent sector?
What would be the implications for providing educational preparation for the role of mentors and senior mentors if the specialist, rather than the generic position, was adopted?

Can mentorship be decoupled from a system in which it is the gateway to career progress?

Is there a means by which relative costs of different models can be assessed?

Resourcing mentorship
Preparing the next generation of nurses was perceived as a complex and resource intensive matter involving diverse personnel in HEIs and healthcare providers with interlinked responsibilities for many aspects of the hinterland that supports the delivery of mentorship. While accepting the need for cost-effective approaches to mentorship, aspects of resourcing required debate.

Can practice education posts be sustained? The project demonstrated the central role in the delivery of mentorship of practice-based posts in trusts and practice-linked posts in HEIs and that it was the interface of these two rather than each acting in isolation that was key to appropriate decision-making and support. If these posts are lost, this would remove vital cogs in the wheel of enabling mentorship to be delivered and hence raise the following questions for debate: how can these posts best be sustained; will trusts take on funding for PEF posts if, and when, SHA funding is withdrawn; and if HEIs rethink the amount of time lecturers spend in practice, will they fund the kind of innovative practice based post as had one of the HEIs in this study?

On-line versus face-to-face learning: While there was acceptance that on-line learning was an appropriate format for disseminating information, this was much less the case for supporting discussions about aspects of mentorship. The effectiveness of further increases in the proportion of on-line sessions in the mentorship course and in annual updates merits consideration. The view that on-line provision is less costly for HEI staff was challenged by participants in this study on the grounds that the set-up and maintenance costs were under-estimated as was the time required by course teachers to support on-line learning; this development also merits further consideration.

What can realistically be delivered and by whom? Looking ahead how can the delivery of student nurse mentorship realistically be sustained and managed in straightened financial circumstances for both HEIs and healthcare providers without compromising adherence to the standards that ensure its quality? Initial steps include: debating and reconciling disparate views on where responsibility for specific aspects of mentorship should lie, as does assessing the feasibility of implementing NMC standards that require time perceived as not having been costed into budgets.

Conclusion
This project focused on the ‘hinterland’ that enabled the delivery of student nurse mentorship and demonstrated its multi-stranded, complex and resource intensive nature. Conclusions did not lead to a specific set of recommendations for practice or further research but rather identified the challenges that mentorship faces and the debates that need to be addressed in considering how it might best develop in the future. Findings come from a London-based sample but are likely to find resonance elsewhere.
We recommend that these challenges and debates be the subject of widespread discussion among those in higher education and healthcare organisations with a remit and a responsibility for the provision and quality of pre-registration student nurse education, in conjunction with professional nursing organisations and the profession’s statutory body, the Nursing and Midwifery Council. That such discussions should commence with some urgency has been highlighted by the recent publication of the Willis Commission report on the future of nursing education which draws attention to the crucial role of mentors in the education that student nurses receive and the training and support that mentors require to fulfil this role (Willis Commission Report 2012).
Chapter 1: Context and purpose

The extent to which newly qualified nurses are adequately prepared to take up the responsibilities of their first post is a key concern for prospective employers and for service and education staff charged with responsibility for student nurse education. One of the major components of student nurse preparation is mentorship - the allocation of each student nurse (mentee) during periods of experience in practice settings (placements) to a qualified nurse (mentor) who guides their practice and assesses their progress. Mentorship is a joint responsibility of higher education institutions and the healthcare providers with which they are associated for purposes of nurse education and is widely regarded as a resource intensive activity in terms of funding, time and expertise.

This report focuses on a project that was commissioned to investigate the perceptions of higher education and service personnel on the capacity of their organisations to meet pre-registration student need for mentorship. The commissioning of the project is described in Section 1.1. The context in which mentorship is delivered is outlined in Section 1.2, while Section 1.3 discusses key developments in the recent history of mentorship. Quality assurance frameworks within which mentorship is situated are discussed in Section 1.4. Subsequent sections of this first chapter are: the aim and the objectives of the project, together with a brief overview of the design (Section 1.5), the research team composition and phasing of the project (Section 1.6), and the structure of the report (Section 1.7).

1.1 Commissioning of the project

The mentorship project is one of four projects commissioned and funded by NHS London to investigate aspects of student nurse preparation for practice. The initiative for these four projects came from a small group of people from London-based higher education institutions (HEIs) and NHS trusts who each have a remit for aspects of nurse education. In response to concerns that students are not always adequately prepared for practice and regarding preparation as a joint service and higher education responsibility, the group identified four aspects of preparation that merited investigation from both perspectives. In addition to mentorship capacity, these are: competences of newly qualifying nurses; factors impacting on employment of newly qualifying nurses; and factors contributing to good outcomes in relation to student nurse attrition. In order to reflect joint higher education and service responsibility for student nurse preparation and early employment, each project was envisaged as a collaboration between a HEI and an NHS trust. The mentorship project was initiated as a collaborative venture between the National Nursing Research Unit of King’s College London and Chelsea and Westminster Hospital NHS Foundation Trust and this is reflected in the composition of the project team (Section 1.6).

1.2 Mentorship in the context of pre-registration nurse education

The word mentor has a common usage in the sense of someone who guides the career of another. A mentor is traditionally described as a trusted guide and advisor with concern for the wellbeing and advancement of the mentee with both psychosocial and career functions (Garvey and Alred 2003). In nursing and midwifery, mentor is also used in this way and has been variously defined in the nursing literature since the 1980s (Andrews and Wallis 1999) with common themes including the ability to befriend (English National Board 1994), inspire (Cahill 1996) and nurture (Bennett 2002). The most common usage of the term mentor in the profession today however, is in the context of
pre-registration education with students (mentees) being allocated to a qualified nurse or midwife (mentor) to guide their practice and assess their progress. And it is mentorship in this pre-registration context that is the focus of this project. At an early stage, it was decided not to include mentorship in midwifery pre-registration education in the project, since it differs in various ways from mentorship in nursing.

Mentorship in nursing has been the subject of numerous policy initiatives from professional and government organisations and its delivery is governed by standards developed by the profession’s statutory body, the Nursing and Midwifery Council of the UK (NMC), thus highlighting the perceived centrality of mentorship in ensuring that nurses are competent at the point of registration. These policies and standards focus primarily on the qualified nurse (mentor) and the student (mentee) and the delivery of mentorship in practice settings. Mentorship has also been the subject of a substantial volume of research and comment reflecting the profession’s ongoing concern with the way in which students are supported in developing and maintaining clinical skills and integrating these with their theoretical knowledge. As with the policies and standards, most of this research, has focused on the delivery of mentorship, in particular, on the relationship between the mentor and the mentee.

However, the delivery and receipt of mentorship is situated within a complex set of roles and relationships between diverse personnel in HEIs and the service providers with whom they link and it encompasses a range of activities and resources which, in turn, are subject to a diversity of contextual influences. Moreover, the nature of mentorship and the ways in which it might develop in the future are the subject of ongoing debate. In this project, we refer to these roles, relationships, activities, resources, contextual influences, and debates as ‘the hinterland to mentorship’. This ‘hinterland’ has been the subject of much less research than that focusing specifically on mentors and mentees but it underpins the delivery of mentorship in practice. The aim of this research was therefore to investigate aspects of this hinterland in relation to capacity for providing mentorship and to do so from the perspectives of staff involved in its provision in higher education and service providers.

Higher education staff provide mentorship courses for service staff who, in turn, once qualified as mentors provide mentorship for student nurses in practice settings. In HEIs, personnel involved in mentorship include: the leads for pre-registration nurse education responsible for the education provided for diploma and degree students; and the leads for post-registration education courses whose remit includes provision of courses for service staff including mentorship. Then there are personnel involved in delivery of the mentorship course: the programme leader responsible for course content and delivery; and the lecturers who teach on the course. The latter may also act as link lecturers and liaise with a specific clinical area(s) in which they provide support for their students on placements and support for the service staff who mentor them. Some of the higher education personnel may also have a remit for identifying and accessing practice settings suitable for student placements. In NHS trusts, personnel involved in mentorship include senior staff who have a remit for aspects of mentorship such as supporting professional development in the workplace, commissioning course places from HEIs, allocating service staff to places on mentorship courses, and assessing placement provision. A key service post is that of the practice education manager/clinical
practice facilitator whose remit includes identifying placements and providing support for mentors and students in practice.

Another post, which may be higher education and/or trust based, is that of the placement allocation manager whose remit is to map student numbers against placement availability and capacity. Relationships between and within HEI and trust staff are facilitated by a variety of mechanisms such as joint HEI/trust practice education committees. Moreover, the two types of organisation are linked by strategic health authorities in relation to the commissioning of student nurse education places and the concomitant provision of their theoretical and practical education.

The foregoing relationships and activities are likely to be influenced by diverse contextual influences. First, directives on mentorship produced by the NMC require staff in both HEIs and trusts to meet a range of standards (Section 1.4). Second, these institutions are subject to a wide range of professional and economic drivers which may affect capacity of staff to deliver mentorship. Recent years have witnessed increasing economic pressures on both types of institutions with implications for ratios of staff to students in higher education and of qualified staff to support workers in healthcare settings. Policies concerning career development may be germane such as an increasing emphasis on research as opposed to teaching activities in higher education and mentorship as a route to promotion in healthcare organisations. Changes in service delivery such as increasing provision of care in community as opposed to institutional settings and service reconfiguring with attendant amalgamations of hitherto separate organisations may also influence capacity for providing mentorship.

Organisational and individual capacities to provide mentorship are the subject of ongoing debates and hence are regarded as part of the hinterland to mentorship. Such debates include: should all nurses be mentors or should the role be developed into a specialist career pathway; how should the funding of mentorship be distributed between HEIs and their associated healthcare providers; which personnel and organisations should be responsible for the different aspects of ensuring mentorship capacity is sufficient; is capacity sufficient to meet the requirements of the quality assurance frameworks within which mentorship is situated, and how should mentorship in nursing develop in the changing financial and professional climate in which higher education and healthcare organisations currently find themselves?

1.3 Policy changes influencing the development of mentorship

A substantial volume of literature is devoted to the subject of mentorship generally and in nursing in particular. Our intention here is not to provide an exhaustive review of the subject and its history since such accounts are available elsewhere (e.g. Gopee 2011) but rather to focus on recent developments in mentorship relevant to the aim and objectives of the project. These include: changes in nurse education and formalising the role of mentors (1.3.1); policies that determine the current shape of mentorship (1.3.2); and changing roles in the support of mentorship (1.3.3).

1.3.1 Changes in nurse education and formalising the role of mentors

The role of mentor has developed significantly in line with changes in education provision (Bray and Nettleton 2007), particularly with regard to responsibilities for assessment (Wilkes 2006). Many practice based professions such as nursing have traditionally used an apprenticeship style of learning
where students work alongside experienced practitioners to learn ‘on the job’ in a practice setting at the same time as contributing to service provision. Early nursing research in the UK identified benefits and challenges to this style of learning as well as the significance of the environmental culture and style of leadership (Orton 1981, Ogier 1982, Fretwell 1980, Melia 1987). There was general agreement that simply working alongside a nurse did not guarantee learning, that the informal processes of student supervision in practice focused on gaining skills rather than integrating theory and practice and that there was inconsistency in the quality of the learning environment. Up to this time teaching in practice was undertaken by clinical tutors or educators and assessment of competence took the form of four summative clinical assessments at specified points within the course usually carried out by the nurse in charge of the ward or a clinical teacher (Wilkes 2006). As MacLaren (2012) observes, there were concerns however, that these post-holders were overstretched and moreover, they did not afford continuity of teaching in practice.

With the introduction of Project 2000 (UKCC 1986) nurse education moved from a hospital to a university base with the majority of practice placement hours having protected supernumerary status. Students joined the roster for service provision during their final placement – a decision that was later criticised as students tended to take on a support worker role at this vital stage of their pre-registration programme rather than roles that would prepare them for transition to registered practitioner. The move to Project 2000 was accompanied by a formal system of mentorship becoming integral to the practical element of the pre-registration curriculum (Myall et al 2008). As this stage, the then English National Board (ENB 1987) defined mentors as counsellors or advisors and subsequently (ENB 1989) as someone selected by the student to assist, befriend, guide, advise and counsel but who would not normally be involved in the formal supervision or assessment of that particular student. As Bray and Nettleton (2007) argue, the focus of the mentor’s role was on facilitating learning and the policies seemed to suggest that the roles of mentor and assessor were separate. Nonetheless, it was observed that many mentors were continuously assessing student performance but were uncertain as to how much supervision of students was needed (Wilkes 2006).

Reviews of research on mentoring undertaken during the 1990s (Watson 2000, Pulsford et al 2002) indicated that students appreciated good mentors, that mentors needed support themselves in being able to fulfil this role and varied in the degree of support that they perceived as being available. The assessment component of the role was becoming increasingly important and this was reflected in the growing trend for nurses involved in teaching students and patients to take an ENB course (No. 998) on ‘Teaching and Assessing in Clinical Practice’; a course which enabled recognition of qualification as a mentor on the professional register (MacLaren 2012).

1.3.2 Key policy documents shaping the development of mentorship

A group of policies on nursing and nursing education published between 1998 and 2001 had considerable effects on the role of mentors and on the delivery of mentorship in practice and, as several authors note (e.g. Bray and Nettleton 2007, MacLaren 2012), led to the formalisation of assessment as an integral part of the mentor’s role. Following a review of standards for post-registration education towards the end of the 1990s, key concerns with the supervision of learners in placements were identified and the resulting report focused on ensuring practitioners were fit for practice at the point of registration (UKCC 1999). Recommendations included the necessity to ensure consistent supervision of learners, by a mentor, in all practice placements thereby
maintaining a supernumerary status throughout the pre-registration programme. As Pulsford et al (2002) observe, the Fitness for Practice report (UKCC 1999) had two key principles which were also echoed in the concurrently published government’s strategy for nursing, midwifery and health visiting (Making a Difference DH 1999): first, greater prominence to be given to practice based learning and acquisition of nursing skills and second, enhancement of partnerships between HEIs and healthcare providers in providing nurse education. Emphasis was placed on the central role of practice-based mentors in teaching students and determining whether they were competent (Pulsford et al 2002, Wilkes 2006).

Further formalisation of the mentor’s role was evident in a joint English National Board (ENB) and Department of Health (DH) publication on the preparation of teachers and mentors (ENB/DH 2001); mentor was defined as: ‘the role of the nurse, midwife or health visitor who facilitates learning and supervises and assesses students in the practice setting’, a change consolidated in NMC guidance in subsequent years (Bray and Nettleton 2007). The environment in which mentorship is delivered was the focus of a DH/ENB report (Placements in Focus, DH 2001) and included regular auditing of practice settings to assess their suitability to enable students to meet their learning outcomes. As such, placement auditing became an integral part of the quality assurance framework for mentorship. MacLaren (2012) observes that both these 2001 reports were influenced by a national study that identified wide variation in assessment practices and effectiveness (Phillips et al 2000).

1.3.3 Changing roles in the support of mentors and students

Changing roles in the support and assessment of students in practice reflect the profession’s ongoing concern with the integration of nursing theory and practice. As the foregoing has noted, prior to the implementation of Project 2000, students were part of the workforce and assessment of their competence was undertaken primarily by clinical tutors. The introduction of supernumerary status was accompanied by a growing emphasis on the role of mentors in supporting students and increasingly involved in assessment as well. Students were also supported by higher education based lecturers who linked with clinical areas in which their students were placed to gain practical experience; support for the students’ mentors might also be part of the link lecturer’s brief. The role of lecturer practitioner was created to further facilitate the integration of theory and practice; posts which were usually joint service and higher education appointments.

The 2001 ENB/DH document on the preparation of teachers and mentors (ENB/DH 2001) led to the introduction of a new role, practice educator, to replace the clinical tutor. These posts were increasingly established from this date onwards, most likely funded by Workforce Development Confederations and more recently by Strategic Health Authorities. Although their titles and specific remits differ, the key aim of such posts is to create a link between theory and practice in clinical areas and between clinical and educational organisations (Clarke et al 2003). Various studies have been undertaken to explore and evaluate these roles (Chapter 2, Section 2.7) and indicate that remits include: supporting students, identifying placements, allocating students to practice settings, supporting the professional development of mentors, and working with students and mentors jointly. An increasing volume of research exists on the efficacy and challenges of the roles of link lecturers, lecturer practitioners and practice educators, some of which is included in the literature review (Chapter 2, Section 2.7).
1.4 A quality assurance framework for mentorship

Increasingly it has been recognised that effective mentors are crucial to the quality of practice learning (Gray and Smith 2000, Myall et al 2008) and to the development of future generations of nurses (Royal College of Nursing 2007). As such, effective mentorship is an essential component of patient safety and hence its provision has increasingly become the subject of quality assurance frameworks developed by the professional and statutory bodies for nursing and midwifery. Quality assurance is usually regarded as a system that measures quality with the aim of assuring stakeholders both internal and external to an organisation that a system meets the defined agreed standards. The NMC, the profession’s statutory body, in the context of its brief for public protection, regularly produced guidance for the provision of mentorship from 2000 onwards and developed a series of new standards.

Following extensive consultation, new ‘Standards to support learning and assessment in practice’ were published in 2006 (NMC 2006). The new standards were implemented in 2007 and replaced all previously published standards; a second edition was published in 2008 (NMC 2008). In 2007 it became a mandatory requirement that UK pre qualifying students, undertaking an approved education programme, are assigned a mentor who works with them for the duration of each of their clinical placements. The new standards aimed, in part, to strengthen existing requirements to ensure students finishing pre-registration programmes were able to practise safely and effectively when they qualify (NMC 2005). The new standards form a broad curriculum of eight domains of practice for mentorship: establishing effective working relationships; facilitation of learning; assessment and accountability; evaluation of learning; creating an environment for learning; context of practice; evidence based practice, and leadership.

1.4.1 Aspects of the NMC standards

The NMC standards encompassed the following aspects of mentorship:

Criteria to be a mentor: Mentors must have held their registration for at least a year and undertaken an approved mentorship preparation course, and met the defined NMC standards for successful course completion.

Mentorship preparation programmes: The new standards required mentorship preparation programmes to have greater emphasis on the skills needed to assess competence, to make difficult judgements and to be accountable for decisions made (NMC 2005). The standards were also influenced by findings from a Department of Health evaluation of pre-registration nursing programmes (Scholes et al 2004) that identified deficits in the nature and quality of clinical practice and the quality of mentor preparation and by the findings of an independent study ‘failing students’ that identified concerns about the reliability and validity of mentors’ judgements (Duffy 2003).

Standards for the preparation of mentors, originally published by the UKCC (2000) as part of the ‘Standards for the preparation of teachers of nurses, midwives and specialist community public health nurses’ were changed from advisory to mandatory standards in July 2003 in order to ensure appropriate support of students in practice (NMC 2004).

While it was recognised that all registrants have a duty to ‘facilitate students of nursing and midwifery and others to develop their competence’ (NMC 2008), a mentor must undergo additional
preparation for the role. The NMC stipulates that the programme must be of ten days spread over a three month period split between the HEI and work-based learning and that five of the days should be protected time.

**Mentor supervisors:** The NMC requires that a mentor supervisor has to verify that the mentorship course student has mentored students in practice by ‘signing-off’ the practical component of the course. Mentor supervisors must have an up to date entry on the register of mentors but do not have to be a sign-off mentor.

**Local register of mentors:** The mentorship qualification is now recorded locally within trusts rather than on the professional register (there maybe some exceptions such as mentors in the independent sector who are recorded on a register held by the HEI). Information on the register includes: names of mentors in the trust; the date of the last annual update and the date when their triennial review is due, and a note to the effect if mentors are no longer active. The register is subject to periodic audit of its currency and effectiveness in the course of NMC audits of institutions.

**Due regard:** Only a registered nurse may sign-off a nursing student at the end of a placement and must be on the same part of the register that coincides with the branch programme that the student has taken. If the mentor and student are not on the same branch, the mentor cannot do a summative assessment of the student.

**Delivery in practice:** Each mentor must not have more than three students at any one time. Each student should spend 40% of their placement working under the supervision of a named mentor.

**Annual updating:** The new standards formalised requirements for professional updating of mentorship skills. Mentors are expected to attend annual updates to ensure that they are informed of issues and changes in pre-registration nurse education. While the format and length of the annual update are not stipulated, every third year must include a face to face discussion between the mentor and the person doing the updating. The NMC states that annual updates are a trust responsibility but that they can involve the HEI in undertaking these collaboratively.

**Triennial review:** A check on each mentor must be made every three years to ensure that they have undertaken annual updates, have mentored at least two students during the three years and have kept a portfolio of evidence of mentoring activities.

**Sign-off mentors:** The new standards introduced a new level of mentor, known as sign-off mentors. Sign-off mentorship entails the mentor assigned to the student in their last placement signing them off as fit for practice with the judgement based on their last placement and on the information recorded in the student’s portfolio. So the sign-off mentor is making a judgement about competence achieved and maintained throughout the course as well as competence demonstrated in the final placement and, as such, emphasises the accountability of nurses who mentor students immediately prior to registration.

**Criteria to be a sign-off mentor:** Sign-off mentors have to meet specific criteria of meeting NMC requirements to remain on the local register and be supervised on at least three occasions for signing off a student by an existing sign-off mentor or practice teacher. Less specific criteria include: being knowledgeable about the pre-registration programme and assessment strategies, and having
an in-depth understanding of NMC registration requirements and of their accountability to the NMC for decisions about competence. The midwifery committee of the NMC decided that all midwives involved in mentoring midwifery students should also be sign-off mentors; this is not the case, however, in nursing.

**Sign-off mentorship in practice:** Sign-off mentors must have an hour a week of protected time with each student. The sign-off mentor may be a different person to the student’s mentor for the placement but if they are one and the same, then the protected hour must be in addition to the student’s 40% of time working with a mentor.

**Placement audit:** Each placement on the circuit for students’ practical experience is audited on an annual basis using standard documentation. The audit is undertaken jointly by the HEI and the service provider.

**1.4.2 Auditing quality assurance frameworks**

These NMC standards are the heart of the quality assurance framework for mentorship. As a joint enterprise between higher education and service providers, audits of mentorship standards by the NMC involve auditing those aspects provided by HEIs, in particular the mentorship course, as well as those aspects under the auspices of the service providers. At the end of each placement, students are required to complete an evaluation of the experience. While these are not part of the required NMC placement audit, they are regarded as part of the quality assurance framework and are usually discussed by service and HEI personnel at the same meeting as the placement audit. Higher education also has its own quality assurance framework; thus each institution is responsible for ensuring appropriate standards are being met and a good quality of education is being provided and the Quality Assurance Agency (QAA) also provides regular assessment of standards and quality of education in each institution. The mentorship course would thus be included in institutional and QAA quality assurance reviews.

Mentorship therefore sits within a number of quality assurance frameworks. The process for measuring quality assurance is usually through an audit or review of practice against standards which shows full, partial or non-compliance with these standards. Audit offers an opportunity to celebrate achievements and identifies areas of practice that need improving. The implementing of development and action plans and then re-auditing completes an audit or quality cycle. However, measuring quality is fraught with challenges and subject to a variety of interpretations and complexities and there is no universal agreement on the best system to manage and measure quality in HEI and healthcare organisations. Questions may arise as to whether measurement of quality is taking the form of a tick box approach to indicate that standards have been met, such as having policies and associated procedures in place, rather than an assessment of the quality of the encounter taking place. The implementation of the quality assurance frameworks for mentorship and debates about its feasibility and efficacy are part of any consideration about capacity to provide mentorship.

**1.5 Aim, objectives and design**

The aim of the project is to investigate the perceptions of higher education and service personnel on the capacity of their organisations to meet pre-registration student need for mentorship. Three
objectives were developed to meet this aim drawing on recent developments in mentorship (Section 1.3); the quality assurance framework (Section 1.4); a review of the research literature (Chapter 2) and a series of discussions between a team reflecting a diversity of research and professional expertise (Section 1.6). Each objective focused on an aspect of capacity.

1. **To understand capacity in terms of resources:** this includes - numbers of mentors, criteria for eligibility, availability of placements, availability and allocation of funds, and direct and indirect costs.

2. **To understand capacity in terms of education and experience of mentors:** this includes - the format and content of the mentorship module, methods of preparing mentors to make judgements about students’ competence and how their ability to do so is assessed, support for mentors while on the course and once back in practice, and preparation of sign-off mentors.

3. **To understand capacity in terms of delivery of mentorship in practice settings:** this includes matching capacity of placement areas to student numbers, providing mentorship alongside other activities, support for mentors and their students, assessment in practice, and monitoring mentorship provision.

Joint HEI and trust responsibility for mentorship is reflected in the project design in that a sample of HEIs and their associated trusts were included; the latter selected to ensure a spread across hospital, mental health and primary care trusts and adult, child and mental health practice settings. In each HEI and each trust, semi-structured interviews were held with key personnel with a remit for mentorship. Each objective was explored in relation to the network of mentorship relationships and activities that exist within and between education and healthcare providers, the diverse contextual factors to which they are subject; and current debates on the subject i.e. the ‘hinterland to mentorship’. This project framework is shown in Figure 1.

Analysis of the interviews led to the development of a framework for considering mentorship capacity and this guided the interpretation of findings and their presentation. The views and experiences of key personnel about the relationships and activities that comprise mentorship and the diverse influences to which these are subject were thought likely to reveal much about mentorship capacity. As such, the project sought to contribute to filling a gap in the research literature on mentorship and to informing debates about future directions for mentorship.
Figure 1: Project framework: The mentorship hinterland – capacity, context and quality assurance

Higher Education Institutions
Provide pre- and post-registration education

- Changing faculty structure
- Financial constraints
- Changing staff priorities
- Resourcing course provision
- Valuing mentorship
- Providing practice education link posts
- Assuring quality of courses

Capacity for providing:

Mentors
- Assessing numbers needed
- Eligibility criteria
- Commissioning places on mentorship courses

Placements
- Finding placements
- Allocating cohorts
- Matching student nos. to placement capacity
- Allocating students to mentors

Healthcare Organisations
Commission student numbers
Provide practical experience

- Changing service organisation
- Financial constraints
- Changing staff skill-mix
- Commissioning policies
- Career progression policies
- Valuing mentorship
- Providing practice education posts
- Care assurance quality
- Assuring quality of care

Capacity for educating mentors
- Diverse levels and formats
- Teaching mixed course membership
- Developing content
- Preparing learners to mentor and assess competence
- Supporting and assessing learner mentors
- Preparing sign-off mentors

Capacity for delivering mentorship
- Preparing students
- Supporting mentors in
  - Managing competing demands
  - Assessing student competence
- Providing professional development for mentors
- Monitoring quality of mentorship

Nursing and Midwifery Council:
Setting standards for: mentors’ education and delivery of mentorship in practice
1.6 Project team and phases

The project team reflected the collaborative approach between higher education and service that characterised this NHS London funded group of projects. Dr Sarah Robinson (SR), Senior Research Fellow at the National Nursing Research Unit of King’s College London, is the principal investigator for the project. For the HEI arm of the research team, Susan Knutton (SK), the lead for the mentorship programme in the School of Nursing and Midwifery at King’s College London, joined the team at an early stage. Initially it had been intended that a part-time research associate would be appointed at King’s College London; however administrative and contractual problems and staff changes meant that this proved not possible. We were fortunate that instead we were able to engage on a part-time basis: Dr Jocelyn Cornish (JC) a lecturer in the School of Nursing and Midwifery at King’s College London with research experience; and Christine Driscoll (CD) an experienced independent healthcare researcher. For the trust arm of the research team, Veronica Corben (VC), assistant director of nursing, education and lifelong learning at Chelsea and Westminster NHS Hospitals Trust, is the trust lead for the project and was joined by Tracy Stevenson (TS), the lead for pre-registration education. This pattern of staffing enabled diverse experience and expertise to be reflected in the design and conduct of the research and provided some members of the group with an opportunity for professional development through gaining research experience.

Commissioning, proposal development and contractual arrangements took place between mid 2009 and September 2010. The project had four phases:

**Phase 1: Preliminary work** (June 2010–February 2011). Further developing objectives and design, reviewing literature, selecting two HEIs and seven trusts; preliminary meetings with personnel in these nine sites; gaining ethical approval from King’s College London for project as a whole, gaining ethical approval for access to HEIs, and developing and piloting interview schedules.

**Phase 2: Fieldwork and obtaining trust approval** (March 2011 to January 2012). Fieldwork in the two HEIs (March and April), preliminary analysis of data, modification of interviews for trust personnel; gaining ethical approval for trust access, fieldwork in seven trusts (November and December).


**Phase 4: Dissemination** (October 2012 onwards). Widespread dissemination to a diversity of audiences, including project participants, through publications and presentations.

1.7 Report structure

The research literature on mentorship is reviewed in Chapter 2 and the research methods and design described in Chapter 3. The findings are presented in five chapters. Chapter 4 details the roles, relationships, activities and resources that comprise the ‘mentorship hinterland’. Mentorship capacity is considered in relation to mentors and sign-off mentors in Chapter 5 and in relation to finding placements and allocating students in Chapter 6. The educational preparation of mentors and sign-off mentors is the subject of Chapter 7 while Chapter 8 is concerned with the delivery of mentorship in practice settings. The findings are drawn together in Chapter 9 in a discussion that includes: implications for future directions in mentorship and a series of debates to be considered.
Chapter 2: Capacity for providing mentorship: findings from the research literature

A substantial volume of research exists on the subject of mentorship. The purpose of this chapter is to present some of the key findings from this work with particular reference to those that inform the objectives of the current study. The approach taken to reviewing and presenting the research is outlined in Section 2.1 and an overview of the various research designs and methods adopted follow in Section 2.2. The studies, presented in six main groups, form the subject of Sections 2.3 to 2.8 with findings and observations about design and methods included in each section. The relevance of the research literature for the current study is considered in Section 2.9.

2.1 Approach to reviewing and presenting the research literature

Research into supporting pre-registration nursing students in clinical practice has a long history and reflects the changing nature of nursing education and policy development in this respect. Much of this research, going back to the early 1980s, focuses on the relationship between the student and personnel who have included clinical teachers and assessors, link lecturers and lecturer practitioners as well as mentors. This project focuses on what we have called the ‘hinterland’ to the mentor-student relationship (Chapter 1, Section 1.2); aspects of this hinterland emerged from the earlier research but have also been the subject of detailed investigation in more recent research.

2.1.1 Search strategy

Our search strategy focused on research undertaken in the UK and elsewhere and published in English from 2000 onwards. Research focusing on student-mentor relationships was included as well as that addressing broader aspects of capacity. Studies were identified through Cinahl and Ovid and through hand searching articles and reports. Given the interchangeable use of mentorship and preceptorship in the UK and overseas literature, the identified studies were reviewed to establish that they focused on supporting student nurse learning as opposed to that of qualified nurses. A total of 36 studies were selected for inclusion in the review.

2.1.2 Subject areas of studies reviewed

A consideration of the studies as a whole, led to identification of six main subject areas and these form the basis of presentation in this chapter.

i) Student experiences of mentorship

Nine studies explored student experiences of mentorship; six focusing on mentorship generally and three on specific aspects of its delivery. The former group included three studies from the UK; Spouse (2001a, b), Kilcullen (2007) and Baglin and Rugg (2010) and three on student experiences of mentorship in other countries: Sweden (Ohrling and Hallberg (2000a, b); Hong Kong (Chow and Suen 2001); and Australia (Van Epps et al 2006). Studies focusing on a specific aspect of the delivery of mentorship included: Lloyd-Jones et al (2001) who investigated contact time between mentors and students; Ross and Clifford (2002) who explored the mentorship needs of final year students; and Gray and Smith (2000) who considered students’ changing needs for mentorship at different points in the course.
ii) Mentors’ perspectives: qualifying as a mentor and providing mentorship

Several of the group i) studies included findings on the mentor’s preparation and understanding of their role, and a second group of studies focused on this more specifically. Watson (2004) investigated nurses’ motivations for taking the mentorship course while Andrews and Chilton (2000) explored the effect of having a qualification on perceptions of mentors’ effectiveness and Hallin and Danielson (2008) the effect on perceptions of introducing more formal preparation for the role. Pulsford et al (2002) considered mentors’ perceptions of the support they received in fulfilling their role and their experiences of mentor updates. Mentors’ attitudes towards their role, and aspects that they found easy or difficult, were explored by Moseley and Davies (2008) while Middleton and Duffy (2009) examined mentors’ experiences and concerns over aspects of providing mentorship in community settings. More recently, MacLaren (2012) has explored the development of nurses as mentors and the way in which other personnel contribute to this process.

iii) The mentor as an assessor of competence

An aspect of the mentor’s role that causes particular anxiety is that of assessing students’ competence, sometimes regarded as being in conflict with the supportive and facilitative aspects of the role. A paper by Neary (2001) drew together studies that she had undertaken on the subject in the 1990s and a further four studies were identified that explored the topic subsequently. Dolan (2003) focused specifically on an evaluation of a revised document for assessing competency while Duffy (2003), in an often quoted study, explored why mentors find it difficult to deal with students whose competence is in question. The third study explored the tensions for mentors in managing the two components of their role (Bray and Nettleton 2007, Nettleton and Bray 2008) while the fourth focused on how mentors make judgements about students’ competence (Webb and Shakespeare 2008, Shakespeare and Webb 2008).

iv) Personnel involved in student learning

While the mentor is the professional likely to be most directly involved in students’ learning in practice, four studies investigated the ways in which other personnel might also be involved. Two focused on clinical staff other than the mentor: in an Australian based study, Brammer (2005) explored registered nurses’ understanding of their informal role in supporting a student’s learning when the student’s designated support person was not present in the practice setting, while Levett-Jones et al (2009) in a UK and Australian based study focused on students’ perceptions of which clinical staff contributed to their learning and to their sense of ‘belongingness’ in the setting. Two studies highlighted a wider range of staff who might be involved in students’ learning in practice: thus Andrews et al (2006) explored students’ perceptions of which HEI staff and clinical staff were involved in supporting them during placement experiences, while O’Driscoll et al (2010) also included a wide range of trust and HEI staff as well as students in a study of participation in student learning.

v) Roles supporting mentors and students

Some of the studies in the foregoing groups identified the role of link lecturers and trust based practice educators in supporting students and mentors. As indicated in Chapter 1, Section 1.3.3, the latter post is a more recent development and, along with link lecturers and lecturer practitioners, has been the subject of several studies that sought to evaluate the impact of such posts. These studies are reviewed in two groups: the first set includes HEI-based roles either solely (Brown et al

**vi) Capacity for supporting the provision of mentorship**

Many of the studies in the foregoing groups raise issues about the capacity of organisations to provide mentorship for student nurses such as time, staffing levels, providing placements, and the preparation and support of mentors and other post-holders. The last group of studies included in this review focused specifically on capacity in relation to clinical placements. Decision-making about the number of students that could be supported in clinical placements was investigated by Hutchings et al (2005) and Murray and Williamson (2009) and strategies to increase placement capacity by enhancing existing areas and/or developing new areas was explored in studies by Magnusson et al (2007) in the UK and by Barnett et al (2010) in Australia. A UK and Finnish-based UK study (Jokelainen et al 2011) explored views as to how organisations should build capacity to ensure high quality practical experience for students.

**2.1.3 The research review as a whole**

To some extent the above groupings reflect the nature of the project in that it starts with the student-mentor relationship (group i) and then moves on to various components that underpin the delivery of mentorship in practice. These include: the preparation and support of the mentor (group ii); aspects of the mentor’s role in making judgements about students’ competence (group iii); the roles of other personnel based in clinical settings in supporting student learning (group iv); posts that are HEI and/or service based and include a remit for practice learning through supporting students and/or mentors and, for some, ensuring placement provision (group v); and finally wider aspects of capacity, especially the matching of student numbers to availability of placements (group vi). The subject areas are not entirely discrete and often issues raised in the course of one group of studies are pursued in more detail in others. The review is comprehensive but not exhaustive.

**2.2 Overview of research design and methods adopted**

For each of the studies presented in Sections 2.3 to 2.8, details are provided of research design and methods and each section includes a consideration of the strengths and limitations of the studies reviewed. A brief overview of the diversity of design and methods employed is included here.

**2.2.1 Range of research design and methods**

The studies varied considerably in scale, design and method and ranged from the use of in-depth interviews with less than ten respondents to large scale surveys by questionnaire involving hundreds of respondents. In studies using interviews, focus groups predominated. Rationales given by authors for designs adopted include: the state of knowledge of the topic and the need, for example, for an exploratory approach; the specific question to be investigated; resources of time and funding; and convenience of access. Authors of several of the studies using qualitative designs attached descriptors to their approach; for example ethno-methodological, phenomenological, natural-constructivist; we have not included these descriptors in this review because of lack of comparability in usage.
2.2.2 Sampling strategies and sizes
Higher education institutions (HEIs) and/or health care providers were the primary sampling units used in most studies, with many adopting a design of one or more HEIs and a sample of associated providers, typically NHS trusts. Purposive, volunteer and convenience samples predominated. Rationales for purposive sampling of specific groups were usually provided; for example final year students, nurses in specific clinical settings, or professionals with specific roles. Larger studies used a variety of sampling techniques including whole population, stratified, random, and cluster sampling. Most authors considered the limitations and strengths of the sampling approach adopted. However, in many of the studies little indication was provided of the sampling strategy used.

In studies in which participants were interviewed individually, sample sizes ranged from six to 30, and in studies employing focus group interviews, samples ranged from 12 to 39 participants contributing to between three and eight groups. Studies described as surveys ranged from 19 to over 400 participants. There was considerable variation between studies as to whether they only included the specific group of interest, for example students or practice educators, or whether they also included the perspectives of others about the group of interest; for example mentors’ and managers’ perceptions of practice educator posts as well as those of the practice educators themselves.

2.2.3 Data collection, response and analysis
Data collection methods included questionnaires, individual interviews (either face to face or telephone), focus group interviews, reflective diaries, participant observation, and document analysis. Varying degrees of structure were described for those studies using interviews and some employed techniques such as the use of critical incidents. Many studies used multiple methods: in some instances one form of data collection informed the development of a subsequent method whereas in others, data obtained from one method were cross referenced or triangulated with those from another. Information about piloting instruments and reliability testing of questionnaires was often provided.

The extent to which response rates could be determined varied since not all authors provided the base numbers from which respondents had been drawn. Response rates varied considerably in surveys by questionnaire and in requests to participate in interviews. Most of the authors discuss the implications of response rates; for example the impact of low rates on reliability and the attribution of high response rates in some cases to the circumstances in which the data were collected; such as at the start of a course at the request of the course leader. In most studies, a clear account is provided of analysis procedures and this is most marked in some of the qualitative studies with detailed accounts of the development of categories and themes and cross checking by research team members of the emerging framework.

2.3 Student experiences of mentorship
Nine studies explored student experiences of mentorship; six focusing on mentorship generally (2.3.1) and three on specific aspects of its delivery (2.3.2).
2.3.1 Studies focusing on experiences of mentorship generally
This group included three studies from the UK and three from other countries.

UK studies of students’ experiences of mentorship
The three UK studies were each based on students drawn from one HEI. Spouse (2001 a, b) used a volunteer sample of eight first year students preparing for adult, child and mental health branches to explore the importance of mentorship in the acquisition of professional knowledge using successive interviews, complemented by observation and documentary analysis. Kilcullen (2007) interviewed a purposive sample of 39 third year diploma students in three focus groups to elicit their perceptions of the impact of mentorship on clinical learning. Second year students on community placements were the focus of Baglin and Rugg’s (2010) study in which semi-structured reflective diaries with a convenience sample of six students were used to explore experiences of the availability of learning activities and views about the value of the community placement.

The role of the mentor in facilitating students’ learning emerged from all three studies. Findings from Spouse (2000a) highlighted the importance of support and guidance from an approachable mentor in enabling students to gain professional knowledge. A second paper from this study (Spouse 2000b) indicated ways in which this acquisition was facilitated and included: helping the student to feel accepted in the clinical setting; assessment of capability and planning of educational experiences; working in partnership with the mentor during episodes of care-giving; and the mentors sharing thinking about the processes they were deploying during care-giving. Respondents in Kilcullen’s study (2007) described ideal mentors as those who helped students socialise into the ward, assisted in the acquisition of clinical skills, gave constructive feedback during the placement, acted as a good role model, and had the ability to integrate theory and practice. Students reported that some of their mentors fulfilled these roles and that the majority were junior staff whom respondents perceived as having a good understanding of their own course. Experience of mentoring in community settings (Baglin and Rugg 2010) showed that working in a team and working closely with a mentor increased confidence and that students commented positively on support in this respect.

Findings from the three studies also revealed students’ perceptions of factors that could hinder their learning opportunities. These included: mentors having to provide mentorship for large numbers of students (Spouse 2000b); mentors feeling unsupported themselves (Kilcullen 2007); and having heavy workloads that led to competing priorities of patient care and student education (Kilcullen 2007, Baglin and Rugg 2010). Students in Kilcullen’s study (2007) reported not always having sufficient opportunity to develop analytic and problem solving skills while those in Baglin and Rugg’s study (2010) attributed a lack of opportunity to gain mastery of practical nursing skills in community settings to increasing delegation of these tasks to healthcare assistants.

Overseas studies of students’ experiences of mentorship
Similar findings in relation to positive and negative experiences of mentors emerge from the three studies in other countries which, like the UK studies, were all undertaken in one HEI. Ohrling and Hallberg (2000a, b) used in-depth interviews to understand the experience of 17 ward-based students selected from a sample of 30 students in the final year of a three year nursing programme in Sweden. A newly established mentoring programme in Hong Kong was evaluated by Chow and
Suen (2001); expectations and experiences of the role of mentors were obtained from semi structured interviews held with a volunteer sample of 22 second and third year students (40% of the student population). Likewise, the study by Van Epps et al (2006) was an evaluation of a new programme; in this case a hospital quality improvement initiative specifically set up for final year students. Thirty nine students opted to take part in the study and were paired with registered nurses who had also agreed to take part; data on their experiences were obtained via questionnaires, focus groups, interviews and student diaries.

The Swedish study indicated students learn from being allowed to practise genuine nursing care and that contact time with the mentor, the use of reflection, provision of concrete examples and control were features of the process (Ohrling and Hallberg 2000a). The study by Chow and Suen (2001) in which responses were coded according to the five aspects of the mentor’s role originally specified by the ENB (assisting, befriending, guiding, advising and counselling) reported positive experiences of all of these. The programme evaluated by Van Epps et al (2006) showed that students appreciated the regular contact with their mentor and that benefits included: developing their clinical skills and gaining confidence from their increasing competence; integrating theory and practice; and a growing socialization into nursing. As with the UK studies, factors were identified that hindered the process of mentorship. Lack of physical space and time for students to reflect on learning either by themselves or with their mentor emerged from the study by Ohrling and Hallberg (2000b) and mentoring expectations being unfulfilled due to mentors’ lack of training for their role and facing the competing demands of patient care and student education (Chow and Suen 2001).

**Strengths and limitations of the UK and overseas studies**

These six studies have various strengths and limitations, some of which are discussed by the authors. Detailed accounts of data analysis procedures were provided and in some instances verification of analysis with participants; some studies were strengthened by triangulation of data from different sources (e.g. Spouse 2001a, Van Epps et al 2006). Sources of bias include motivation of respondents taking part in volunteer samples and participants being potentially vulnerable to a ‘power relationship’ when studies take place in the researcher’s institution. Generalisation from a study undertaken in one institution is limited but considered in conjunction with other similar studies contributes to building up an overall picture of factors facilitating and hindering the process of mentorship from the perspective of students.

**2.3.2 Studies focusing on a specific aspect of students’ experiences of mentorship**

Three studies focused on a specific aspect of the delivery of mentorship: contact time with mentor and students’ changing needs for mentorship at different stages of the course.

Lloyd-Jones et al (2001) found considerable variation in the extent to which students and their named mentors worked together. A sample of students across all branches of nursing (n=270) and their named mentors from 14 NHS trusts in three geographical areas were asked to complete activity diaries for one week as part of a larger cost-benefits analysis study of clinical placements. Among the student respondents (n=125, response rate 46%) and the mentor respondents (n=117, response rate 45%) there were 81 student-mentor pairs. Data from these pairs showed that 31 worked on the same shift every day, 48 a mixture of the same and different shifts, with just two pairs not working together at all. Lack of working together was partly a function of differences in shift patterns.
Findings suggested that the students who did not work with their named mentors spent less time in educational activities and adopted a more passive role in clinical care. However, patient-related activities were separated from educational activities in the analysis, suggesting that patient-related activities were perceived as having no educational component.

Students’ changing needs for mentors emerged from a longitudinal study in one HEI by Gray and Smith (2000). Data were obtained from a volunteer sample of 10 adult branch students who were interviewed on five occasions throughout the course and from a further seven volunteers who kept diaries only. Findings charted the changing role for mentors at different points of the students’ education; thus they were vital to the students at the start of training but diminished in importance towards the end. Similarly, dependency on the mentor reduced once the students had settled into placement and knew what was expected of them. By the end of the foundation programme, students articulated the qualities they associated with good mentors and these included: being approachable and friendly; being good role models (professional, organised, confident in own ability, and enthusiastic about their job); ability to pace their teaching to student need; and provide constructive, critical feedback. Having a good mentor coincided with perceptions of having a good placement.

The importance of mentorship for final year students in one institution emerged from a study by Ross and Clifford (2002) focusing on the transition from student to newly registered nurse. Thirty students from a total of 177 students in the third year of a diploma course volunteered to take part and were asked to complete a questionnaire about their experiences and expectations (19 did so) and of these 13 completed a post-qualification questionnaire. In between these two time-points, four of the 19 responded to a request to be interviewed. One of the key findings was that more positive and directed support was wanted from mentors during the final year alongside acknowledgement that mentors were not sufficiently supported themselves at times to do so. The authors report that these findings were discussed at mentor workshops.

In terms of strengths and weaknesses of these three studies, two share characteristics with studies in Section 2.3.1 in that they were volunteer samples in one institution. The study by Lloyd-Jones et al (2001) has the strength of including 14 trusts and all branches of nursing, although it is not entirely clear from the paper how some components of the sample were selected. Findings from these studies amplify some of the findings from those reviewed in 2.3.1 such as perceived characteristics of good mentoring and factors that limit the process such as mentors lacking support themselves and the impact of shift patterns on contact time.

2.4 Mentors’ perspectives: qualifying as a mentor and providing mentorship

The second group of studies focused on mentors’ perspectives: their motive for training; the effect of having the qualification on perceptions of effectiveness; views about specific aspects of their role; support from others; and attending professional updating sessions.

2.4.1 Qualifying as a mentor

A diverse range of motives for attending a mentorship course emerged from a study by Watson (2004). Registered nurses from two secondary care trusts attending a mentorship course (n=127) were invited to complete a questionnaire that explored commitment towards the role of mentor
and reasons for undertaking the training (n=115, response rate=90.6%). Reasons included commitment to becoming a mentor, requirement for promotion, enhancing overall job prospects, and to enable the clinical areas in which they worked to be approved as a placement area for students.

The effect of holding a mentorship qualification on perceptions of mentoring effectiveness was explored by Andrews & Chilton (2000) in two wards at one District General Hospital in Wales. A small purposive sample of staff nurses who were mentors (n=22), half of whom held one or other of the teaching and assessing qualifications available at that time, were asked to rate their own aptitude for mentoring by completing a questionnaire that included the Measuring Mentor Potential (MMP) scale (Darling 1984). These ratings were then compared with those given by students (n=11) allocated to members of the staff sample. Findings indicated that students rated their mentors positively, irrespective of whether or not they held a mentorship qualification, and consistently rated their mentors higher than did the mentors themselves. However, among the sample of mentors, those with a qualification rated themselves as more effective than those without and were more confident in their roles. The potential impact of formal preparation was also considered in a Swedish study (Hallin and Danielson 2008) in which experiences of acting as a mentor were compared prior to (2000) and after (2006) the introduction into practice of a model of mentorship. Questionnaires sent to independent groups of registered nurses at the two time points revealed improvements in mentor preparation, support for the role and in positive attitudes towards the role. Workload, feedback, and support in linking theory to practice showed least improvement.

2.4.2 Working as mentor: role delivery and support
Mentors’ perceptions of support received in undertaking their role and experiences of mentor update sessions emerged from a study by Pulsford et al (2002) as part of a wider project to improve partnership working between one HEI and its associated trusts. A questionnaire was sent to a sample of 400 mentors selected from the approved list held by the HEI. The sample was achieved by randomly selecting one mentor from every second clinical placement from the overall list of placements to ensure representation of all practice areas and branches in the study; the response rate was just under 50% (n=198). Findings showed that the majority felt supported by work colleagues but fewer felt that they had adequate support from the HEI or their managers. Increased support wanted from trust managers included more time for mentoring activities and assistance in managing multiple demands on time. Increased support wanted from HEI staff included closer links before, during and after practice placements and more user friendly documentation. Recency of attending a mentor update varied (this study took place before annual attendance was mandatory); lack of attendance was attributed to staff shortages (47%), lack of prior information (29%), inconvenient times (22%) and lack of interest (2%). Respondents wanted greater flexibility in provision of updating with a slight preference for written information and sessions held in practice areas rather than at the HEI.

Mentors’ attitudes towards their role and the aspects that they found easy or difficult were investigated by Moseley and Davies (2008). A group of mentors (n=104) who were being trained at the HEIs in which the authors worked and were currently supporting students in practice were invited to participate in a study by questionnaire. Respondents (n=86, response rate 89%) covered all branches of nursing. Overall, respondents had a positive attitude towards mentorship but
reported difficulties arising from work organisation such as workload and skillmix. Analysis of components of the mentor’s role made a distinction between the social and interpersonal aspects and the cognitive and intellectual aspects such as the mentor’s knowledge of the student’s programme, being updated on mentorship issues, and aspects of assessment and feedback for students. It was the latter aspects of their role that mentors were more likely to find difficult and the authors recommended that greater attention be paid to these in training programmes for mentors.

Specific challenges of providing mentorship in community settings for final placement students were highlighted in a study by Middleton & Duffy (2009). Community nurses working in a city based community health practice were purposively selected to include those qualified as community nurses who had completed a mentorship programme and had mentored at least one final placement student. This sample was then invited to take part in the study and the 12 volunteers were interviewed in three focus groups. Findings showed that mentors liked the longer final destination placement (17 weeks) in that it was perceived as beneficial to student learning and confidence. However, they found it challenging to provide students with a mini caseload that would enable them to meet learning outcomes for registration. Respondents indicated that they were acutely aware of their responsibilities as sign-off mentors but expressed concern about the level of accountability entailed, particularly in relation to what they perceived as pressure to pass final placement students and a lack of support when faced with a failing student.

In an innovative design employing three methods, MacLaren (2012) explored the development of mentors in their practice setting; an aspect of mentorship which has received little attention hitherto. Semi-structured interviews were held with three recently qualified mentors and three other mentors whom the former regarded as significant others in their development. Key themes included: what it meant to be a professional nurse; differing orientations to learning; and how mentorship was regarded as part of a learning trajectory. The second part of the study explored the way in which the domains of mentorship were evident in interviewees’ descriptions of their mentorship practice; giving critical feedback and making judgements about student competence emerged as the domains with which newly qualified mentors felt least confident. In the third phase, interviewees drew a constellation of their perceptions of the strength of the relationship between themselves and significant others: supervising/experienced mentor; ward manager; practice education facilitator; and university lecturers. Relationships described as most supportive in development as a new mentor differed between interviewees, but were regarded as an important component of this process. Findings were drawn together into a series of tensions that may shape workplace mentorship learning and development.

2.4.3 Key points from studies of mentors’ perspectives on mentorship

A range of strengths and limitations of these studies was identified, often by the authors. Strengths included: reliability testing of questionnaires; attempts to deal with potential conflicts when participants were known to the researcher, for example when attending a course; and multi-methods approaches to little understood subjects. Andrews and Chilton (2000) observe that students in their study completed documentation about their mentors for the research project prior to receipt of their final report from the placement. Limitations of generalising from single site and/or convenience samples were acknowledged.
Taken together, these studies contribute to building up the picture of mentorship and amplify some of the issues raised in studies of students’ perceptions of mentorship (Section 2.3) such as mentors facing competing priorities and the extent to which mentors are supported in their development and practice. Additionally, from the mentors’ perspective, these studies highlight diverse motivations for the course, positive impacts of the course on perceptions of effectiveness, and the view that the assessment component of the mentor’s role is particularly challenging. And it is this last mentioned point that is the focus of the next group of studies.

2.5 Studies focusing on the assessment component of mentorship
Several studies conducted in the 1990s highlighted the tensions in the mentor’s role occasioned by a combination of facilitating and supporting students on the one hand and being their assessor on the other (e.g. Neary 2001). Subsequent studies have pursued various aspects of this topic in more detail and four are included in this review.

Evaluating a competency document
A range of issues concerned with assessment emerged from a study in one university by Dolan (2003) which aimed to evaluate a revised competency document. The document was discussed in eight focus groups (four with students from the first two cohorts to use the new system, two with mentors and two with tutors). Students’ documentation relating to assessment of clinical competency was content analysed. Findings indicated concerns that the revised system was not effective at measuring all the attributes of clinical competency and that there was not an adequate balance between developing skills and gaining an holistic experience of care. There were inconsistencies in the way in which statements in the document were interpreted, differing interpretations of the amount of written evidence required and concerns about lack of time for completing the assessment document during the normal clinical working day, particularly for mentors with several students. Students reported positive and negative experiences in relation to mentors’ interest in them and their willingness to spend sufficient time on the assessment process. Mentors reported that student numbers frequently overloaded placement resources to provide support and both mentors and tutors highlighted mentors’ reluctance to write negative remarks about students.

Failing to fail students
The challenge for mentors in being critical of students was highlighted in particular in a frequently quoted study by Duffy (2003). The aim of the study was to investigate mentors’ and lecturers’ experiences of dealing with students whose clinical competence was in question and their perceptions as to why some student nurses were being allowed to pass clinical assessments without having demonstrated the requisite level of competence. A volunteer sample of 14 lecturers from three Scottish HEIs was recruited to the study, followed by 26 mentors from practice placements associated with these institutions; most had been involved in situations in which a student’s competence had been questioned and/or been failed. The majority worked with adult branch students but the other three branches were also represented. Participants were interviewed individually.

Findings showed that both mentors and lecturers were aware of the problems entailed in failing a student and recognised that borderline students were sometimes given the benefit of the doubt.
‘Failing to fail’ a student was attributed to staff not recognising and acting on concerns about competence early on in a placement, the consequences of failing a student becoming increasingly difficult as the course progressed, and the emotional challenges involved in failing a student. Good practice was identified as having an action plan for a failing student early on in the placement and regular communication between the HEIs and the practice area. Experience, confidence and adequate preparation were identified as crucial for mentors who had to deal with failing students as was adequate support from lecturing staff. Some tensions were noted between mentors and lecturers over priorities when faced with failing students. Duffy (2003) concluded that mentors needed better preparation for their role and responsibilities in relation to failing students, recognition of their accountability in allowing students to qualify, and that adequate support for this process was required from both their practice and education colleagues.

Tensions in the mentor’s role

That the dual nature of the mentor’s role, facilitating learning and assessing competence, continued to be problematic was evidenced in subsequent studies. Two papers, Bray and Nettleton (2007) and Nettleton and Bray (2008) focused on the changing nature of the role of mentors, in particular the inclusion of assessment in the role alongside the more traditional roles of facilitating learning and being a support. Data were obtained in the course of a large scale study of the mentor’s role in which questionnaires were sent to mentees and mentors in the disciplines of nursing, midwifery and medicine in five acute trusts in North West England. For each group, response rates were considerably lower for mentors than mentees with the greatest range in nursing (from 13% of mentors (n=110) to 60% of mentees (n=174). Respondents were invited to participate in a subsequent interview and for the nursing group, 20 mentors and 20 mentees agreed to do so.

The first paper (Bray and Nettleton 2007) showed that when asked to select the most important role that mentors fulfil, all three professional groups were less likely to select assessor than teacher, supporter and role model and that assessor was also the role most likely to be selected as difficult to fulfil. Interview data reported for the nursing sample revealed concerns about the assessment aspect of the mentor’s role and time to complete the assessment document. The second paper (Nettleton and Bray 2008) focused mainly on respondents’ views on what changes would improve the system of mentoring; those identified reflect many of the issues that emerged from studies included in previous sections of this review and included: greater recognition of the role of mentor; staff being able to choose whether or not they became mentors; and staff having more time to fulfil their mentoring responsibilities. The authors argue that all these aspects of mentorship have assumed greater urgency with concerns about managing failing students and increasing emphasis on assessment aspects of the mentor’s role.

Making judgements about competence

Another study specifically explored the way in which mentors make professional judgements about the clinical competence of students and is reported in two papers (Webb and Shakespeare 2008, Shakespeare and Webb 2008). A convenience sample of nine third year students and 15 mentors, selected to include a range in terms of experienced, recently qualified and in training, were recruited from two institutions, one in the north and one in the south west of England. Participants were interviewed face to face or by phone (five mentors) or in a group (four students) using a critical
incident technique in which interviewees were asked to talk about a mentoring incident that was significant for them and key to their mentoring relationship.

The first paper (Webb and Shakespeare 2008) focused on the relationship between students and mentors, with particular attention drawn to: the way in which students were aware of the need to present themselves as enthusiastic, confident, assertive and competent; the way in which mentors responded positively to these characteristics; and the crucial nature of this relationship in mentors making judgements about students’ competence. Other findings included: students and mentors both reporting positive and negative experiences of the mentoring relationship; mentors having difficulty in giving negative feedback to students; and concerns over insufficient time for mentorship to be provided. The second paper (Shakespeare and Webb 2008) provided an in-depth analysis of those aspects of the interviews concerned with communication between mentors and students and revealed how both parties used communication to show ‘competence and skill (or lack of it) and the ability to take on professional identity’ (p.277).

**Key points from studies of assessment component of the mentor’s role**

Strengths of these studies include: piloting of questionnaires; high questionnaire response rates from some groups; and clear exposition of processes involved in analysis of interview data. Limitations include generalising from geographically restricted sites, small convenience samples and low response rates. As a group, these four studies illuminate several aspects of the assessment component of the mentors’ role: concerns about the extent to which assessment documents measure competence; the complex and time consuming nature of completing assessment documents; anxieties over making negative judgements about students; pressures against failing students; lack of support in dealing with such students; and the diverse range of influences that may contribute to a judgement about a student’s competence.

**2.6 Studies exploring personnel involved in supporting students’ learning in practice**

While the mentor is the professional likely to be most directly involved in students’ learning in practice, four studies investigated the ways in which other personnel might also be involved. Two focused on clinical staff other than the mentor and two highlighted a wider range of staff.

**2.6.1 Role of other clinical staff in students’ placement experience**

Brammer’s study (2005), undertaken in Australia, was concerned with student learning when their designated support person was not present in the practice setting. In this situation, the student would be informally ‘buddied’ with a registered nurse (RN) for the day and the study explored the understanding that RNs had of this role and the approach adopted to its fulfilment. Interviews were undertaken with a purposive sample of 30 registered nurses from 15 sites that included a balance between metropolitan and regional locations. Analysis identified eight variations of understanding of this informal role; these ranged from student centred, through completion of workload centred and registered nurse control to preference for no contact with students. The author concluded that RNs need better preparation for this informal role since it is likely to be an important component of students’ learning experiences.

The importance of the mentor’s role emerged from a study by Levett Jones et al (2009) of the influences of relationships with clinical staff on students’ learning and their sense of belongingness.
during placements. Third year students in three universities, two Australian and one British, who had completed an online survey were invited to participate in a subsequent in-depth interview phase of the study. On the basis of information provided by those volunteering, 18 were selected to provide a range of demographic characteristics in the sample. For each of the relationship themes identified from the data (receptiveness towards student on arrival, being included in the team, valuing of the student role, recognition of students’ contributions to patient care, and a blend of challenge and support), findings revealed both positive and negative experiences of the role played by clinical staff, including that of their own mentor.

2.6.2 Range of staff involved in students’ placement experience

The study by Andrews et al (2006) explored students’ perceptions of the role played in their learning by various personnel present in practice settings. The study was based in two HEIs and participants from degree and diploma courses were recruited from advertising in these institutions; they took part in seven focus groups with between 10 and 18 participants in each. Telephone interviews were also held with 30 geographically dispersed ex students randomly selected from university records. Findings showed very diverse experiences of placements in relation to the following: the ward manager’s role in the overall environment of the ward; the ward manager’s attitude to students; the extent to which mentors appeared prepared for their role; the extent to which support was forthcoming from the student’s link lecturer; the degree of contact between the link lecturer and the mentor; and communication between the HEI and trust; for example, over whether a placement area was expecting the student.

On the basis of the findings and their own professional experience, the authors developed a series of models of relationships between students, mentors, link lecturers, ward staff and the ward manager that detailed communication links between these personnel and the frequency with which they were deployed. The models included two developed from the data; one of current worst practice and one of current best practice. Two further models were developed, categorised as recommended minimum best practice and recommended best practice; the latter also included the post of practice educator in the network of links.

The study by O’Driscoll et al (2010) also explored participation of different personnel in student learning in practice with interest focusing on how changes to the NHS workforce and higher education might have impacted on responsibility and leadership for this learning. Using four NHS Trusts as case study areas, an online version of a ward learning questionnaire was sent to all pre-registration nursing students in the four sites; the response rate was 20% (n=937). This was followed by individual, joint and focus group interviews with a sample of a wide range of staff that included mentors, ward managers, lecturers, and practice educators as well as various clinical posts. Participative observation, in-depth interviews with students, and analysis of curriculum documents also contributed to this multi-methods study.

Respondents’ perceptions of direct and indirect involvement in student learning suggested that roles may be changing (O’Driscoll et al 2010). Ward managers had key leadership roles in creating a positive clinical learning environment but this could be overshadowed by increasing managerial functions. Link lecturers appeared to be facing increasing uncertainty over the extent of their involvement in learning in practice. Various clinical specialist posts had a professional remit for
learning in practice but not one that involved direct contact with students. Day to day responsibility for student learning lay with mentors but they were challenged by difficulties such as modelling a role that is becoming increasingly technical, managing competing priorities, and unrealistic student expectations. Healthcare assistants played a significant role in providing learning opportunities for students.

2.6.3 Key points from studies about personnel involved in students’ learning in practice

One of the strengths of these four studies is that each drew from more than one institution; HEIs in the case of two studies and healthcare providers in the other two. Three studies explored the topic from the perspective of one group, students or registered nurses, and there was some acknowledgement that other perspectives would strengthen conclusions. Generalisation from the O’Driscoll et al (2010) study was strengthened by the inclusion of all groups likely to have some level of responsibility for student learning but the low response rate for the student component of the study limited generalisation from this group. As authors acknowledge, the strategy of volunteer sampling in two of the studies runs the risk of attracting mainly those with negative experiences and creating a potential bias in the views expressed.

The contribution of these four studies lies primarily in increasing understanding of the role played in student learning by a diverse range of people employed by healthcare providers and by lecturers employed by HEIs. Of particular note are findings that suggest that some of these roles may be changing in terms of the contribution that they are able to make to student learning.

2.7 Roles to support mentors and students in practice placements

Some of the studies in the foregoing groups identified the role of link lecturers and trust based practice educators in supporting students and mentors and these along with lecturer practitioners have been the subject of several studies that sought to evaluate the impact of such posts.

2.7.1 Studies that included HEI posts solely or jointly with practice posts

Findings about the role of link lecturers in supporting students during placements emerged from a study by Brown et al (2004). Noting a lack of research into students’ views and experiences of the role of the lecturer in practice, they invited a cohort of 65 third year adult branch students in one nursing school in Scotland to participate in focus groups to consider the subject; 25 agreed to do so. Findings from the five focus groups indicated much variability in the support provided by individual lecturers in relation to direction about the learning process, objective setting, feedback, problem-solving, acting as an advocate for students, and monitoring their professional development. There was a consensus from the students that their lecturers had a key role in enabling students to cope with clinical practice but that this could only be effective if the lecturer was present in the clinical area.

The role of link lecturer was also considered in a study by Carnwell and colleagues that sought to explore the roles of mentors, lecturer practitioners and link tutors (lecturers) in assisting students to integrate theory and practice; a 2007 paper from the study reports the views of senior NHS and HEI managers on these three roles. The managers were purposively selected from three trusts and two HEIs in Wales as having recently been involved in changes to nurse education (n=22) and took part in four focus groups (three with NHS managers and one with HEI managers). Findings showed that
managers thought that the roles differed in terms of relationships with students: mentors focus on individual students, lecturer practitioners on the learning environment as a whole, and link tutors on the curriculum and knowledge acquisition; thus 'link tutors teach theory, which lecturer practitioners help students to apply in practice, with the help of a mentor' (p.926). All three roles were perceived as subject to conflict, mainly attributed to competing demands on time and/or meeting expectations of different organisations. Various options were put forward as to how these roles might develop in the future with some reallocation of responsibilities in the quest to bridge the theory-practice gap.

Dual education and practice posts to facilitate bridging the theory-practice gap were the subject of a study by Williamson & Webb (2001); lecturer practitioners and a more recently introduced post of clinical facilitator, the two referred to collectively as clinical support nurses. The study, which was undertaken in one HEI and the trusts with which it linked, focused on the effectiveness of these two posts in supporting students in clinical practice. All clinical support nurses (n=45) were invited to participate in three focus groups: 56% agreed to do so (n=25). These 25 staff were asked to nominate an NHS senior manager familiar with their work for participation in a telephone interview; however it only proved possible to interview six of the 26 nominated. Five focus groups were also held with a convenience sample of pre- and post-registration students from the four branches (of those approached (n=72) 47% took part (n=34).

Findings indicated that these dual education and practice posts offered opportunities for professional development and helped bridge the theory-practice gap for both HEI and trust employees (Williamson and Webb 2001). Effectiveness in fulfilling roles increased with growing experience and was viewed as dependent on good interpersonal relationships between trust and HEI staff. Students, however, reported little experience of support from either post holder although indicating that such support would be welcome. Insufficient time spent with students was attributed by the two groups of post-holders to conflicts in balancing the clinical and educational aspects of their role, with the former having to take priority and that this, along with other aspects of their posts, would benefit from clarification.

While each of these three studies was based in a limited number of sites, with acknowledged limitations of, for example, convenience samples and low response rates for some groups, an overall picture emerges of how posts with a dual education-practice remit can facilitate both individual student learning and communication between HEIs and associated trusts. The studies also suggest that post-holders are not always able to deliver the amount of support that students and/or they themselves would wish and that this is attributed to competing priorities and insufficient clarification of their role.

2.7.2 Studies of practice based support roles
The second set of studies in this group focus specifically on practice based roles with slightly differing remits and titled variously; clinical placement co-ordinator (Drennan 2002); practice placement facilitator (Clarke et al 2003); practice development facilitator (Larsen et al 2006); practice educator (Jowett and McMullan 2007) and practice education facilitator (Carlisle et al 2009). The studies include evaluations of posts in Ireland, England, Wales and Scotland. Although most are large scale studies involving a number of institutions and a range of methods, they differed considerably in
rationale, focus and scope and so are considered separately with those findings in common then drawn together.

**The clinical placement co-ordinator in Ireland**

In Ireland, the changing focus of the work of university lecturers, as well as increasing workloads for registered nurses in managing patient case loads and mentoring students, led to the development in 1997 of a hospital funded post of Clinical Placement Coordinator (CPC) to provide support for student nurses in clinical areas. Drennan (2002) sought to evaluate this relatively new role for general, mental health and learning disability programmes in the course of a study that included various stakeholders (e.g. clinical placement coordinators, directors of nursing, nurse tutors, registered nurses and students). In Stage 1, interviews and focus groups were held with 166 of these stakeholders sampled from 10 randomly selected nurse education institutions. Questionnaires, based on themes identified in Stage 1, were then sent to CPCs, clinical nurses and student nurses using a random proportional sampling design; response rates were 66%, (n=79), 56%, (n=168) and 61% (n=121) respectively. Findings suggest initial confusion and variation in the role of the CPCs attributed by respondents to inadequate definition and tensions created by the dual nature of the role in ‘supporting yet policing’ students. There was an emerging consensus that the role was becoming progressively clearer. Student respondents valued the support positively, particularly in helping them make sense of their clinical experience.

**The practice placement facilitator in North East England**

An evaluation of a similar role, this time entitled practice placement facilitator, was the subject of a study by Clarke et al (2003) in three trusts in North East England. The post holders had each practised in their trust and were seconded to, and managed by, the university for the duration of the post. The aim of the study was to evaluate the impact of the role in the provision of practice placements, the support of students during placements and the professional development needs of clinical staff acting as mentors. Placement capacity and placement usage for all branches of nursing, midwifery and a range of primary and secondary care settings was calculated from university and trust data. Questionnaires were used to ascertain the profile of all learners in these clinical areas. In one trust a more detailed analysis of placement usage and experience was undertaken and focus groups held with 20 students to explore their placement experience. Focus groups to explore the PPF role were held with university teachers associated with one of the trusts and with the PPF in each of the three trusts.

The PPFs’ role included much more day to day work in placing students, often at very short notice, than they had anticipated. Their role, which was perceived as developing positively, included supporting clinical staff in understanding students’ needs and in revealing new and/or unresolved issues in relation to clinical learning. As with studies reported in Section 2.3, students reported both positive and negative experiences of mentorship, but in this study were also unanimously positive about the role of the PPF in supporting them during the placement. Although students reported that the distinct roles of university lecturer and PPF were both important in supporting their learning, the PPF was more likely to provide greater continuity. Both PPFs and HEI clinical link tutors reported some tensions over potential overlap and conflict between their roles and the need for clarification and recognition of respective input (Clarke et al 2003).
Placement capacity was also investigated in this study; a point pursued in more detail in Section 2.8. Findings showed that trusts were using 80% of their total audited capacity for pre-registration nursing students and that this discrepancy was attributed in part to the complex pattern of diverse groups of learners, non-nurses as well as nurses, requiring clinical experience. PPFs indicated that an increase in placement capacity would have to come from better use of existing areas since new areas were unlikely to be forthcoming and were concerned about potential tensions between the demand for places and the quality of the experience.

**Practice educator post in England**

Jowett and McMullan (2007) report on an evaluation of a practice educator (PE) role, established as an initiative between an HEI in England and associated trusts. Their evaluation focused on the effectiveness of the practice educator’s role from the perspective of the post-holders, mentors and students. All the PEs in post (n=24) were asked to participate in one of four focus groups. Emerging findings were used to develop questionnaires sent to all 284 second year students and their mentors on how they perceived the PE’s role; response rates were 46% (n=131) and 38% (n=97) respectively. Key findings from all three groups of participants included the following: PEs were perceived as supportive to both mentors and students; they acted as an important link between the HEI and practice providers; and their high credibility, accessibility and approachability were essential attributes of their role.

**Practice development facilitator posts in South East England**

Larsen et al (2006) report on an action research project focusing on support for newly created Practice Development Facilitator posts (PDF) as part of a partnership working initiative between an HEI and associated trusts in South East England. The focus of the role was described as developing ‘an organisational culture that supports innovative and creative practice and the learning and integration of new skills’ (p.8). The first phase of the project focused on gaining an understanding of the support needed by PDFs to meet the expectations of their role. The challenging nature of these expectations was reflected in having to integrate trust wide strategic policies with clinical needs and concerns at practice level, and having to balance national agendas, such as NMC standards, with the particular circumstances of their own trusts. Success in fulfilling the role was perceived as depending on the PDF’s professional and personal qualifications and on support structures. In subsequent phases of the project the PDFs, with support from the action research team and others, designed and developed their trust-based learning activities into an accredited work-based programme that could be recognised by the university; a pilot programme was then evaluated. Phase 3 focused on the introduction of PDFs into primary care trusts in a way that built on experiences in the previous two phases. Findings emphasised the complexity of the PDFs’ role and the need for ongoing support, including accredited work-based learning programmes.

**Practice education facilitator posts in Scotland**

A three year project by Carlisle and colleagues in Scotland sought to evaluate the implementation and impact of the role of Practice Education Facilitator (PEF) introduced in 2004 to ensure the quality of student experience primarily through the support of mentors. In a 2009 paper, Carlisle et al report findings from the study that focus primarily on the perceived impact of the role of the PEF in that respect. Phase 1 of the study entailed a scoping study of the role of PEFs through questionnaires sent to all those in post; the response rate was 71% (n=84). Six case study sites
representing diverse practice settings were selected following a consensus conference on the phase 1 findings. Phase 2 entailed questionnaire surveys of mentors (n=69, response rate 26%) and students (n=31, response rate 21%), focus groups and telephone interviews with key stakeholders (n=34, response rate 32%).

Findings suggest wide acceptance of the PEF role across Scotland and recognition of its value in developing quality clinical learning environments. Mentors seemed better supported in their role as evidenced by: timely allocation of students to mentors; preparing mentors prior to students arriving; increasing their understanding of the pre-registration programme and the assessment process; and providing helpful and timely advice on managing failing students. Numerous examples of good working relationships between mentors and their PEFs were described and, since their introduction, many clinical areas reported being more pro-active in producing tools to support student learning. Concerns were expressed that the PEFs’ workload was such that on occasions they seemed to be ‘fire-fighting’ and sometimes had low visibility in the clinical areas. Concern was also expressed that HEIs did not feedback results of student evaluations of placements sufficiently quickly and examples were given of PEFs trying to remedy this situation.

Key points from studies of practice based support posts
The study by Larsen et al (2006) differed from the others in adopting an action research approach and demonstrated the importance of involving post-holders in the ongoing development of strategies to support their work. The other five studies employed robust designs in which the views and experiences of those holding the practice based post were explored alongside the views of other key stakeholders including students, mentors and senior managers. All employed a range of methods, usually questionnaire surveys preceding or following focus group interviews. Reliability testing of questionnaires was evident and while response rates varied, the limitations on generalisation of some of the lower rates are acknowledged.

Although the specific remit of the posts and focus of the studies differed, some common findings emerged. As the posts became established, responsibilities became clearer following some initial role confusion. The post-holders were viewed positively by students who welcomed the support offered. Mentors likewise reported ways in which they felt supported. Challenges to the role emerged from some studies and included: workloads that led to a sense of fire-fighting; lack of clarification of the role in relation to that of the link lecturer; and the challenge of meeting needs of different organisations and at different levels within the same organisation.

2.8 Studies of organisational capacity for providing mentorship
Many of the studies mentioned thus far raise issues about the capacity of organisations to provide mentorship for student nurses such as time, staffing levels, providing placements, and the preparation and support of mentors and other post-holders. The last group of studies included in this review focused specifically on capacity in relation to clinical placements.

2.8.1 Studies focusing on decision-making about placement capacity to support students
Decision making about the number of students that could be supported in clinical placements was explored from the perspective of key stakeholders in a study by Hutchings et al (2005). A purposive sample of mentors, nurse managers, and modern matrons, recruited from a diversity of clinical areas
in one English NHS trust, were invited to take part in focus group interviews. The response rates for each group were low at 28% (n=4), 18% (n=4) and 25% (n=4) respectively and, as the authors acknowledge, meant a potential lack of representativeness. Factors identified as impacting on placement capacity included: student numbers were decided through an educational audit but regarded as not always matching the number respondents felt could be supported; audits were sometimes out of date and did not reflect the ‘current operational climate’; difficulties in supporting students as well as newly registered staff at busy times especially when the skillmix comprised a high proportion of bank and agency staff; and having insufficient numbers of mentors to implement recommended mentor-learner ratios. Other findings reflected those in some of the studies on practice support roles (Section 2.7). Thus all participants believed that an increased amount of dedicated academic support from HEI staff would improve the learning environment by providing mentors with advice about assessment issues and helping them with ‘difficult’ students; and participants in areas which had appointed a trust-based education facilitator commented positively on their support for mentors.

Murray & Williamson (2009) also explored decision-making in relation to the numbers of students that can be supported per placement. A sample of 29 mentors in one strategic health authority, purposively sampled to include adult, mental health and child branch nursing from various acute and community settings, were recruited into three focus groups. Questions built on those developed by Hutchings et al (2005) and similar findings emerged. While mentors most often reported that decisions about the number of students an area could support were made by ward managers, the majority thought that such decisions should be made jointly by the placement manager and clinical team and the HEI. Concerns were expressed about peaks and troughs in the numbers of students in practice and short notice of anticipated student arrivals. The ratio of mentor to students featured prominently in responses and factors perceived as hindering mentoring included: constraints of staffing levels and workload, students being unwilling to work night duty or weekend shifts, and the time consuming nature of assessment processes and associated paperwork. Mentors thought that students as well as themselves had a responsibility for making the relationship work and that mentors would benefit from an occasional break from having a student.

2.8.2 Studies focusing on enhancing and increasing placement capacity

As part of a wider project to map clinical placement provision for students at four universities in the south-east of England and then identify and explore opportunities to enhance such provision, Magnusson et al (2007) captured the views of seven Clinical Placement Managers (CPMs) on the subject. This post was funded by the local Workforce Development Confederation (WDC) and had a remit to: manage the provision of placements; support managers, supervisors and assessors in practice; and provide strategic links between the WDC, HEIs and their associated trusts. In-depth interviews were held with a purposive sample of seven of the 27 CPMs in post, selected to represent a diversity of practice settings.

Clinical Placement Managers were seen as having a bridging role between the placement, HEI and student. Their detailed knowledge of the trust and its clinical areas facilitated the management of placement allocation and this knowledge, combined with the use of forums, networks and mapping exercises, helped them to identify new areas to develop for placements. There was a strong feeling among CPMs that educational audits did not provide an accurate reflection of a placement’s actual
capacity; a finding also reported by Hutchings et al (2005). Factors hindering expansion of capacity included: HEI staff being slow to respond to requests to audit new areas that CPMs had identified; placements not being accessible for students without private transport; student reluctance to work evening and night shifts; increases in numbers of part time staff; and reluctance of some mentors to have students after a gap in doing so.

Some of the problems about capacity to accommodate student nurses identified in the foregoing studies were addressed by a hospital in Australia and the three educational institutions with which it was associated through the development of a collaborative education model (Barnett et al 2010). Using a participatory action approach, a group of senior staff delineated the key attributes of the model that included: leadership; commitment and regular face to face communication by all key stakeholders; a common support and reward programme for mentors (called preceptors in Australia); a dedicated clinical facilitator; greater use of different shifts and weekends for placements; a reconfiguring of student placement timetables from each education provider; expanded number of placement weeks available at the hospital; and the education providers developing common clinical objectives, skills sets and student evaluation tools. The model was phased in over two years and evaluated by an assessment of placement metrics and a survey, focus group discussions and interviews with students, mentors and senior education and management staff. Findings showed that all aspects of the model were viewed positively by participants and the placement metric data for the three-year project period showed an increase of 58% in the number of students placed at the hospital and a 45% increase in the number of placement weeks available.

2.8.3 Study of broader aspects of organisational capacity

A broader perspective on organisational capacity for mentorship emerged from a study by Jokelanien et al (2011) in which a purposive sample of mentors from Finland and the UK were interviewed in focus groups (five groups in Finland (n=22) and four groups in the UK (n=17). While the paper indicates that the mentors were drawn from a diversity of practice settings, information is not given on the geographical or institutional spread of the sample. The interviewees were asked for their conceptions of how to build organisational capacity for providing effective mentorship for students during placements. Three categories of organisational capacity emerged from the data analysis, each at a different hierarchical level, and demonstrated the complexity of organisational resources, strategy and commitment that mentors perceived as necessary to underpin their support of student learning in practice.

The highest level focused on the organisation as ‘an optimizer of sufficient executive investment in providing mentorship’ and this included: a clear, co-operative strategy for placement provision; sufficient human and financial resources (numbers of mentors, protected time for mentorship, education and updates during work time, and financial rewards for mentorship); and a culture that valued mentors and supported their work and professional development. The second level focused on the organisation as a creator of a supportive culture in placements and this included: professional and enthusiastic attitudes to work; positive attitudes to mentorship; a student centred atmosphere; and a focus during work on students’ learning objectives. The third level focused on the organisation as a provider of well prepared placements and included: appropriate staffing levels and workloads; matching student numbers to placement capacity; preparation for arrival of and allocation of students; and attention to providing learning opportunities.
2.8.4 Key points from studies of organisational capacity

Limitations of the studies, often author acknowledged, include: lack of information of size of group from which the sample was drawn; low take up of requests to participate in study; recall of interview content when note-taking as opposed to audio-recording is used; researchers known to participants; and generalizing from one site and/or small groups.

Considered together, the studies highlighted a wide range of factors that can influence organisational capacity to provide and support placements for student learning and these include: accuracy of audits to determine placement capacity; insufficient numbers of mentors for students; high proportions of temporary staff; peaks and troughs in student numbers in practice; and short notice of students’ arrival. The importance of joint decision-making about placement capacity and the need for posts that support student learning in practice were both identified. The interest of the Australian study is in demonstrating that a different and collaborative approach to some of these problems can result in enhancing the capacity of healthcare organisations to support student learning in practice.

2.9 Relevance of research literature to current study

The review has demonstrated the wide variety of aspects of capacity for providing mentorship that have been investigated and the diversity of design and methods adopted to do so. This final section considers the relevance of the studies reviewed to the aim of the current study. For each of the three objectives (Chapter 1, Section 1.5), a brief summary is provided of findings relevant to the aspects of mentorship that it encompasses with an indication of the chapter section from which the findings are drawn.

Objective 1: Capacity in terms of resources

Findings from the literature review relating to this objective include:

**Student numbers and placement capacity:** Disparity between the number of students a placement can support as assessed by educational audits and perceptions of staff in the practice setting, educational audits being out of date; importance of joint HEI-trust decision-making about capacity; trusts not always using agreed capacity; student numbers overloading the capacity of the placement to provide support; and peaks and troughs in the number of students in the setting (Section 2.8).

**Increasing placement capacity:** A range of sources of information are used to find new placements; various factors, however, can limit the ability to develop these (Section 2.8).

**Placement management:** Problems identified include: practice educators having to place students at very short notice; practice settings given very little notice of student arrivals; and finding a sufficient caseload for students in community placements (Sections 2.7 and 2.4).

**Becoming a mentor:** Staff wanting a choice as to whether they take on the role of mentor, and diverse motivations for taking the course ranging from individual commitment to student nurse education, career progress and meeting organisational needs (Section 2.4).

Objective 2: Capacity in terms of education and experience of mentors

Findings from the literature review relating to this objective include:
Perceptions of mentors’ preparation for their role: There was much variation in the extent to which students perceived mentors were prepared for their role; formal preparation for the role increased mentors’ perceptions of their effectiveness; mentors were likely to regard the assessment component of their role as more challenging than the aspects concerned with facilitating learning; and working relationships in practice that supported newly qualified mentors were important in developing confidence in the role (Sections 2.4 and 2.5).

Professional updating: Attendance was most likely to be prevented by staff shortages (Section 2.5).

Preparation for roles that support mentors and students: Preparation is now being developed to support practice education posts (Section 2.7).

Objective 3: Capacity in relation to delivery of mentorship in practice
A high proportion of the studies reviewed related primarily to this objective and included:

Relationship between mentor and student: Students identified a range of qualities that they associated positively with mentors and these included: approachability, providing constructive feedback, being willing to work together and allowing student to work on their own; being a good role model; focusing on providing learning opportunities; assisting with integration of theory and practice; and with socialization into nursing. Positive and negative experiences of these attributes were documented. Students’ needs for mentorship varied at different points in the course (Section 2.1).

Factors affecting delivery mentorship: These included: competing priorities of patient care and student education; contact time with mentor; perceptions that some mentors are not sufficiently prepared for their role and/or lack support themselves (Sections 2.3 and 2.4).

Support for students from other personnel: A range of personnel were identified as providing support to students in varying ways and included: the role of other clinical staff including the ward manager, in welcoming students and supporting their learning; support from link lecturers was valued although the extent of their presence in clinical areas varied; and the new practice educator roles were viewed positively by students (Sections 2.6 and 2.7).

Support for mentors: Students differed in their perceptions as to whether mentors were supported (Section 2.3); mentors themselves reported the following: they felt supported by colleagues; there was a more mixed picture in relation to support by ward managers and by link lecturers; and support from practice educators was viewed positively (Sections 2.4, 2.6, and 2.7).

Assessing competence: this aspect of the mentor’s role was perceived as particularly challenging and this was manifest in: mentors may be reluctant to provide negative feedback to students; may fail to highlight concerns sufficiently early; and give borderline students the benefit of the doubt. Diverse influences affect the way in which judgements are made about competence. The importance was highlighted of both preparation of mentors for this aspect of their role and of support from HEI and practice staff in managing failing students (Sections 2.4 and 2.5).

Clarification of roles in supporting learning in practice: diverse post-holders support learning in practice including link lecturers, lecturer practitioners and, more recently, practice educators.
Studies of respective roles indicated that there may be potential overlap between roles and that responsibilities may require clarification (Sections 2.6 and 2.7).

**Deploying the literature review findings**

The findings from this literature review informed the development of the aim and objectives of the project (Chapter 1, Section 1.5); the development of the interview schedules (Chapter 3, Section 3.4), and contributed to the context within which the project findings are discussed.
Chapter 3: Research design and methods

Research design and methods are described in this chapter. An overview of the design is provided in Section 3.1 together with issues of validity and reliability in a design of this kind. Sampling decisions and negotiations for access are discussed in Section 3.2 and the process of obtaining ethical and managerial approval to undertake the project in Section 3.3. Subsequent sections focus on: developing and piloting the interview schedules (3.4); undertaking the fieldwork (3.5); and processes of data analysis (3.6). These aspects of the project were spread across the four phases of the research as described in Chapter 1, Section 1.6. The chapter concludes with some observations on the generalisability of the findings (3.7).

3.1 Choice of research design and methods

During the preliminary phase of the research, which included reviewing the literature and a series of team discussions (Section 1.6), the project aim and objectives were developed (Section 1.5) and decisions made about research design and methods. A review of research relevant to the project objectives (Chapter 2) in consideration with resources available to the research team, led to a decision to undertake a series of semi-structured interviews with personnel in two HEIs and a sample of the healthcare providers with which they were linked for purposes of nurse education.

3.1.1 Decisions about units of investigation and personnel to be included

The design was chosen to reflect joint organisational responsibility for mentorship and thus included HEIs and their linked healthcare providers; in this respect it was similar to many of the studies reviewed in Chapter 2. The literature review had revealed that much of the research to date has focused on mentorship in hospital based adult nursing services but that when other services and settings were investigated some important differences had emerged, a similar finding to earlier work undertaken in the National Nursing Research Unit on, for example, the provision of preceptorship (Robinson and Griffiths 2009). Given the need to understand potential diversity as well as similarities in mentorship capacity for mental health and child branch students as well as adult, and the increasing emphasis on moving care from institutional to community settings, we decided to include a broad range of services and settings. Consideration was given to the inclusion of mentorship in the context of learning disability branch students and settings but decided against, partly on grounds of resources but also on the changing nature of learning disability nursing education, for example, the increasing provision of placements in social care settings.

Key people identified in HEIs who had a remit for mentorship included lecturers on pre-registration programmes who also linked with practice settings in which students had placements; the leader of the mentorship programme, leads for the pre-registration branches and a range of senior personnel with remits that included various aspect of mentorship. It was recognised that this latter group would likely differ from one institution to another in relation to the precise remit and responsibilities of their post. Another key role in mentorship provision was that of teaching on the mentorship module; some HEIs have a separate group of staff for this purpose whereas in others it is part of the role of staff involved in lecturing.

In the healthcare providers the post of practice education facilitator was recognised as central to the provision of mentorship. As with the studies reviewed in Chapter 2, Section 2.7, preliminary work
indicated that post titles were likely to differ; in this report they are referred to collectively as practice education facilitators (PEFs). The second group in the healthcare providers were senior staff with a remit for education. As with the HEIs, preliminary work indicated that these varied considerably from one healthcare provider to another and decisions as who to include would have to await the access phase of the project (Section 3.2). Consideration was given to including a sample of mentors but decided against partly on grounds that the focus of the project was on the perceptions of others about capacity to underpin delivery of mentorship in practice and partly on grounds of resources. Throughout the report, the healthcare providers included in the project are referred to collectively as trusts since independent healthcare providers were not included. Where appropriate, distinctions are made between NHS hospital trusts, primary care trusts and mental health trusts.

3.1.2 Decisions about data collection methods

The literature review provided an indication of what was known about different aspects of each of the project’s three objectives in relation to capacity (Section 2.9). In considering how best to explore these objectives further, it was recognized that while several aspects of mentorship capacity such as course costs and course format could be ascertained through a questionnaire, many others required exploration through interview; for example the question of whether all nurses should be mentors, a topic on which there were known to be varying views. Hence a semi-structured interview was chosen as the best way to gather data offering a combination of pre-determined factual questions, questions exploring specific experiences, and open-ended questions. As Tod (2010) observes, such a format enables control and direction of the interview to lie with the researcher, offers capacity to be responsive to the interviewee’s agenda, and retains sufficient flexibility necessary to follow issues raised by participants that had not been anticipated.

Interviews, whether structured, semi-structured or unstructured, have the capacity to describe, explain and explore issues from the perspective of participants. As Hammersley and Atkinson (1995) argue, interviews are evidence of perspectives of particular groups but at the same time display cultural particulars that in turn express and reveal social structures and, in that sense, they are ‘displays of reality’. Likewise, Miller and Glassner (1997) maintain that while qualitative interviewing enables researchers to gain an understanding of views and experiences of research participants ‘these narratives come out of the worlds that exist outside of the interview itself’ and thus also provide a means of learning about the social world (Miller and Glassner 1997,p.105). In this project, semi-structured interviews were deployed to provide an understanding of the perceptions and experiences of people involved with mentorship and, as such, what these reveal about organisational and individual factors that influence mentorship capacity.

3.1.3 Decisions about approach to analysis

Approaches to analysis of qualitative data vary in terms of their focus and aims (Spencer et al 2003). The focus of this project was to illuminate aspects of mentorship capacity with the aim of informing debates on the subject as well as contributing to policy development. The method of analysis adopted drew on an approach known as Framework and which was developed by Ritchie and Spencer (1995) as being particularly suited to analysis of qualitative data in projects with an applied and policy focus. The stages of this process are usefully summarised by Lathlean (2010) as follows: gaining familiarity with the interviews through repeated reading and/or listening to recordings;
identifying a thematic framework based on a priori issues, emerging themes and concepts; indexing all the transcripts with codes representing the constituent parts of the framework; charting the coded data by re-arranging and synthesising it according to themes in the framework; and lastly, mapping the range and nature of the phenomenon, creating typologies, and searching for associations. The way in which this method of qualitative analysis was applied in this project is described in Section 3.6.

3.1.4 Validity and reliability

Although a variety of terms are used in qualitative research for validity and reliability (such as credibility and trustworthiness respectively), drawing on Lewis and Ritchie (2003) we use the former. Validity in qualitative research is concerned with ‘are we accurately reflecting the phenomena under study as perceived by the study population?’ (Lewis and Ritchie 2003, p.274). In this respect, validity is concerned with: inclusiveness of selection criteria; capturing the phenomenon through questioning that allows participants to fully express/explore their views; labelling phenomena in ways that reflect meanings assigned by study participants; providing sufficient detail to evidence the explanatory accounts developed; and displaying findings in a way that remains true to the original data and allows others to see the analytic constructions that have occurred.

Reliability in a qualitative study is concerned with likely recurrence of the original data and the way these are interpreted. The former is concerned with ensuring that all features likely to be relevant to the problem have been included in the sample and so the phenomena are not location bound. Reliability of interpretation is concerned with: consistency in the fieldwork; a systematic and comprehensive approach to the analysis; ensuring that the interpretation is supported by the evidence; and allowing equal opportunity for all perspectives to be identified (Lewis and Ritchie 2003).

The following account demonstrates how we approached all these aspects of validity and reliability.

3.2 Selecting the sample and negotiating access

3.2.1 Sampling strategy

The project funders, NHS London, required that the fieldwork be London–based since their concern was the adequacy or otherwise of the preparation of London based pre-registration students. It was not feasible with project resources to include all HEIs, associated trusts and relevant personnel in London and so a purposive sampling strategy was adopted in which settings, people and events thought likely to be relevant to, and offer different perspectives on, the research problem were selected (Silverman 2000, Ritchie et al 2003). Our intention was to include a diversity of practice settings in the project and this entailed at least one acute, one mental health and one primary care trust associated with each of the selected HEIs. The decision was to include two HEIs and a sample of three or four trusts associated with each, in order to achieve a balance between representativeness of diversity and availability of resources.

Two of the London HEIs that had a nursing/healthcare faculty were selected on the basis that together they represented diversity in terms of:

- Geographical location (one inner city and one suburban);
• Approach to teaching the mentorship course (one employed a separate group of staff for this purpose, in the other it was part of the remit of most lecturing staff);

• One had appointed a group of staff with specific responsibility for practice education in one or more of the associated trusts;

• One had a central team for placement allocation whereas the other approached this on a more local basis.

Care was also taken not to include HEIs already selected for one of the other three ‘Readiness for Work’ projects. A list of trusts associated with each of these HEIs was compiled and preliminary consideration given to a possible sample.

3.2.2 Negotiating access and identifying personnel for interview

A preliminary access meeting was held with a senior person in each HEI with the purpose of: explaining the project and requesting participation; identifying the range of staff with a remit for mentorship in the HEI in one form or another; and gaining further information about the trusts with whom the HEI was associated for purposes of nurse education. Both indicated their agreement in principle for their institution to participate. At one HEI, the key person then provided information about the project to colleagues via email accompanied by a copy of the project protocol. At the other HEI, two members of the team gave a presentation at a meeting attended by key HEI and trust personnel involved in mentorship. Once agreement had been obtained in principle from the head of faculty/department and other senior personnel, preliminary discussions were held about which staff have a remit for mentorship and who would subsequently be asked to participate. The next stage in accessing HEI personnel was to obtain permission from the HEI’s research ethics committee to interview staff in the department (detailed in Section 3.3.1).

Based on the initial list of trusts associated with each of the two HEIs and further information obtained in the course of access meetings with HEI personnel, a selection was made that included a mental health trust, a trust providing generalist services other than mental health, and a primary care trust associated with each HEI. For one HEI, a trust providing specialist services was also included, making a total of seven trusts. During the access meetings it became apparent that both HEIs were making increasing use of the independent sector for pre-registration nurse education and that staff employed in this sector were now attending the HEI’s mentorship programme. While it was outwith project resources to include staff in the independent sector, we decided to include lecturers who linked with independent providers so that specific issues pertaining to this sector would be included in the project.

The main contact in each HEI identified a key potential participant in each of the selected trusts. Access meetings were then arranged with each of these people, some of whom had asked other colleagues to be present as well. At these meetings, the purpose of the project and implications for staff time were explained; in each case agreement to participate in principle was secured and further information provided about which staff had a specific remit for mentorship.

Throughout the access period, it was made clear that the project would not be of benefit for individual participants but rather provide the opportunity to participate in a project that aims to
Contribute to greater understanding of the hinterland that underpins the delivery of mentorship and hence to developing good practice for mentorship. An undertaking was given that a copy of the executive summary would be sent to all participants with details of how to access the full report. Emphasis was placed on the voluntary nature of individual participation and ways in which anonymity and confidentiality would be maintained and that the next stage would be to obtain ethical approval for the institution to participate. Everyone we met was pleased that the project was taking place and keen to be involved. The decision to include a diversity of services and settings in the project was further confirmed in the course of access meetings with HEI and trust personnel who drew attention to their perceptions of setting differences as well as similarities.

By the end of the access meeting stage of the project, decisions had been made as to which groups of people to include in the project.

HEIs: Groups represented in both HEIs included: the mentorship module leader; personnel with a strategic, overview remit that included mentorship; and personnel with responsibilities relating to specific programmes and/or practice areas. Groups represented in one but not both HEIs included: a separate mentorship teaching team; a central placement allocation team; and staff with specific responsibility for practice education in the trusts with which the HEI linked.

Trusts: Groups represented in all seven trusts included senior posts that had a primary or sole remit for education that encompassed mentorship; and posts that involved supporting education in practice, known variously as practice educational facilitators, practice education managers, and clinical education facilitators (referred to as practice education facilitators (PEFs) throughout this report).

3.3 Gaining ethical and managerial approval
Ethical approval to undertake the project was obtained from King’s College London Research Ethics committee during the preliminary phase of the project in conjunction with obtaining ethical approval from the research ethics committees of the two HEIs (3.3.1). This was followed by obtaining approval from the NHS research ethics service (3.3.2) and then from the research and development departments of each of the seven trusts which focused on managerial issues as well as research and ethical issues (3.3.3). Some of the specific ethical issues raised by the research are reviewed in Section 3.3.4.

3.3.1 Gaining ethical approval from research ethics committees of King’s College London and the two selected HEIs
The project was submitted to the King’s College research ethics committee in June 2010. There was ongoing discussion between the Principal Investigator (SR), the committee’s officer and chairperson about the order of events in relation to obtaining ethical approval for the project from King’s College and from the two HEIs selected for participation. Preliminary discussions with officers for the Research Ethics Committee in the two HEIs said that they would be willing to grant ethical approval on the basis of full ethical approval having been granted by the Kings College Research Ethics Committee; the latter however, would only give approval in principle for the project until approval had been granted by the Research Ethics Committees of the two HEIs.
Ongoing negotiations with all parties to resolve this conundrum resulted in: approval in principle granted by King’s College Research Ethics Committee in July 2010 (ref. no: PNM 0190/140); the first HEI providing full approval by October 2010, Kings College then giving full approval for work to commence in this HEI but in principle only for the other; the second HEI providing full approval in December 2010 and King’s College giving full approval for the project as a whole in early 2011. Requests were then made asking individual HEI personnel to participate in the project (3.5.1).

3.3.2 Gaining approval from the NHS research ethics service
A full application was made to the NHS Research Ethics Service, identifying a lead trust, and accompanied by the interview schedules for trust staff; these were slightly modified from the pilot study versions in light of further information obtained. At the time, the NHS Research Ethics Service was piloting a system known as proportionate review for projects that do not entail substantial contact with patients and hence could be assessed within a shorter time frame. This necessitated completing the full form and then requesting consideration under proportionate review; this was granted and approval for the project secured in July 2011 (ref. no 11/LO/0949).

3.3.3 Gaining approval from research and development departments for selected trusts
Initial approaches to the Research and Development (R and D) departments of each of the seven trusts were made while the full application was under review to ascertain what documents each would require. Once ethical approval was obtained from the NHS Research Ethics Service, application was made to each of the trusts for approval to undertake the research; the main issues raised in this process were as follows.

i) Requirement to have a research passport
There was considerable difference of opinion between trust R and D departments about whether research passports were needed by the research team and if so, whether Criminal Records Bureau (CRB) and /or Occupational Health (OH) clearance was needed in order for the passport to be granted. The NIHR 2010 guidance clarifies this situation in stating that CRB and OH clearance are not needed for research that only involves interviewing staff. After much discussion between the various parties concerned, including King’s College research personnel, trusts agreed to conform with the NIHR 2010 guidance in this respect. The lead trust processed and certified the research passports and these were then made available to each of the other trusts requiring this level of documentation.

ii) Variation in information required
All trusts required the Integrated Research Application System (IRAS) generated site specific form and the NHS R and D form, copies of the interview schedules, the consent form, participant information sheet, and researchers’ CVs. They differed over whether the following were required: completion of their own R and D forms as well as those generated by IRAS; peer reviewing of the proposal by a trust committee; the degree of costing information; and waivers for research governance training.
iii) Definitions of and requirements for separate principal investigators, authorising manager and local collaborator

There was considerable difference of opinion between trust R and D departments over accepting the IRAS distinction between the Chief Investigator (the lead researcher making the application) and the Principal Investigator (the trust member of staff appointed to lead the research in each trust). Although all forms were completed following this distinction, some trusts required revisions on the grounds that as far as they were concerned, the lead researcher (SR) was the Principal Investigator. Likewise there were differences between trusts over whether there could be any overlap, and hence potential conflict of interest, between the trust principal investigator, the line manager who gave permission for staff to be approached for participation and a local collaborator. Negotiations were undertaken in each trust to secure agreement of the specified individuals to undertake these roles.

iv) Obtaining letters of access

Each R and D department provided a letter of access for each researcher once the foregoing processes were completed and approval from all trusts was secured by the end of October 2011. There was considerable variation between trusts in the length of time entailed in achieving this outcome (from three weeks to five months) but throughout the whole process in each trust, all the R and D staff were extremely helpful. The impression gained in some instances was of staff dealing with a very large number of applications and in a situation in which the guidance provided to them was not always clear, was sometimes contradictory, or was in the process of being revised.

3.3.4 Specific ethical issues

The ethical issues encompassed in the documents provided for the various organisations detailed above included standard measures to ensure confidentiality, anonymity and security and included:

- Emails to potential and agreed participants would only be sent from password protected computers and each person would be sent a new email to avoid any possibility of emails being forwarded that contained information about other participants.
- Participants would be interviewed at their work place in a location where the content of the interview could not be overheard by anyone else.
- Digital recordings would be uploaded on password protected computers to a transcription agency regularly used by the NNRU and with whom a confidentiality agreement is signed for each project. The transcriptions company’s site is password protected and sound files are deleted from the company’s electronic files after three months.
- Hard copies of transcripts would be stored in locked cabinets in locked offices for seven years and then securely destroyed.

Of particular concern to the research team in writing this report and a point made clear in the applications for ethical approval was that of identification of sites and individuals in a project that adopted a purposive sample of a few individuals from each of nine organisations in a named part of the country. Many of the participants had post titles that were organisation specific. Hence we have adopted generic titles for each group and made every attempt to present the findings in a way that individuals and locations cannot be identified by third parties.
3.4 Developing the interview schedules

Work on developing the interview schedules was ongoing throughout the preliminary phase of the project and had three stages:

- developing the list of topics to be investigated (3.4.1)
- developing and piloting the interview schedules (3.4.2)
- revising schedules and gaining familiarity with use (3.4.3)

3.4.1 Developing the list of topics to be investigated

A list of topics related to the three project objectives was developed on the basis of the policy context (Chapter 1, Sections 1.3 and 1.4), the literature review (Chapter 2) and the diverse expertise encompassed within the research team (Chapter 1, Section 1.6). The list was then further developed on the basis of discussions with a small pilot group drawn from higher education and service and from information obtained in the course of access meetings (Section 3.2.2).

The final list had five sections: the first focused on the interviewee’s role and position, the next three on the aspects of capacity that comprised the project’s objectives, and the final section on some broader issues relating to mentorship as a whole.

**Section 1: Interviewee’s role and position**

- post title and role in mentorship
- links between own organisation and others associated with nurse education
- how own responsibilities for mentorship relate to those of others in trust(s) and HEI(s)
- participation in mentorship mechanisms such as committees, working groups

**Section 2: Capacity in relation to resources for mentorship**

- role in: finding and assessing placements; ensuring sufficient numbers of mentors and sign-off mentors
- views about any difficulties associated with types of placement
- role in deciding how many students a placement can support and perceptions of match between student numbers and placement capacity
- role in gaining students for the mentorship module
- views on criteria for being a mentor, sign-off mentor, such as qualities required, relation to promotion, views on whether all nurses should be mentors and all mentors should be sign-off mentors
- knowledge and views of costs and resources entailed in mentorship

**Section 3: Capacity in relation to educational preparation for mentorship**

- format and content of mentorship module and mode of delivery
• views on advantages and disadvantages of face to face and on-line delivery
• preparing course members for assessment component of role
• adequacy of course as preparation for role of mentor
• support for mentors from HEI and trust while on course
• mode of, and responsibility for, sign-off mentor preparation
• involvement in, and views about, annual updates and triennial reviews
• joint working between organisations in relation to mentorship preparation
• examples of good practice and suggestions for improvement in the education and support of mentors

Section 4: Capacity in relation to delivery in practice
• allocation of students to mentors and mentoring systems such as co mentors
• perception of whether time for mentorship is protected and how mentors balance patient care and student education
• support for mentors in practice and links between organisations for supporting mentors (and students)
• mentorship documentation
• views on soundness of mentors’ judgements about student competence
• systems for monitoring quality of mentorship
• factors that facilitate or hinder delivery of mentorship and examples of good practice

Section 5: Mentorship as a whole
• NMC requirements: keeping up to date with standards, views on implications of their implementation, involvement in validation events
• contextual factors – potential effects on mentorship of changes in healthcare and higher education providers
• indirect costs of mentorship
• views on effects of mentorship and on how mentorship is valued
• having authority to fulfil own responsibilities in relation to mentorship

3.4.2 Developing the topic list into interview schedules
During the preliminary phase of the project, the range of post-holders to be included in the HEIs and in a sample of their associated trusts had been finalised (Section 3.2.2). Our intention was to cover
the same set of topics with all interviewees in order to be able to compare and contrast across posts and settings but to word each appropriately for the particular responsibilities of each of the key personnel involved. Each topic was developed into a question and wording adapted to fit what was known to date for each of the posts identified. As Tod (2010) observes, the aim in developing an interview schedule is to achieve a balance between direction and flexibility thus enabling the central research question(s) to be addressed while also allowing for new perspectives to emerge. Consideration was thus given to focusing on the various aspects of project objectives while not precluding new points from emerging.

Question types included: background information (e.g. post and links with other organisations); behaviour and experience (e.g. aspects of role in finding placements and difficulties that might be entailed); knowledge (e.g. cost of mentorship courses); and beliefs (e.g. should all nurses be mentors). Consideration was given to the order of the questions; it has long been observed that those about beliefs and feelings are more challenging and need to be approached gradually (e.g. Whyte 1960, Measor 1985, Tod 2010). In this project, the placing of questions such as views as to whether all nurses should be mentors and having the authority to fulfil one’s own responsibilities for mentorship needed careful consideration within sections and within the interview as a whole. Prompts were included in some questions with the purpose of facilitating interviewees to expand on issues of particular interest.

The interview schedules were piloted with 12 people representing a spread across relevant posts in HEIs and trusts and on the basis of which, some of the questions were expanded and/or re-worded; an example of the final schedule for a trust interviewee and for an HEI interviewee are available from the authors. The piloting also provided an opportunity for team members to revisit skills of being a critical listener in the context of this subject. Although all team members have had extensive interviewing experience, each project raises new challenges in this respect over, for example, how best to phrase a question, gaining a sense of how long it takes to cover each section, and to be able to judge those sections when people might be most likely to move away from providing relevant information.

3.4.3 Revising schedules and developing team familiarity with their use
Once the interview schedule was finalised, team members each practised one of the interviews with another member of the team. It was thought that the likely length of interviews might be perceived as a burden by some respondents and further practice enabled us to streamline the interview as much as possible by ensuring maximum flow between questions and sections and avoiding repetition. A decision was taken to digitally record the interviews rather than take notes on the grounds of: ensuring an accurate and comprehensive record of the interview; facilitating the maintenance of eye contact and rapport; and observing non verbal cues such as expressions of unease that indicate a topic might usefully be further pursued. This practice period also provided time to gain familiarity with the use of digital recorders. An interview is usually a ‘one-shot’ chance at obtaining information and adequate preparation was therefore deemed essential.

3.5 The fieldwork
The fieldwork was undertaken in two stages: stage 1 in the two HEIs (March and April 2011) and stage 2 in the seven NHS trusts (November and December 2011).
3.5.1 Interviewing participants in higher education

Once ethical approval had been granted, final decisions were made about which individuals to include from the groups identified in Section 3.2.2. With senior staff with a cross-programme remit for education, there was only one person in each of the various posts regarded as relevant to mentorship; they held a diversity of titles and varying remits for pre and/or post registration education and some had posts with a specific focus on practice-based education. In each HEI, there was one person who had overall responsibility for the mentorship programme and both were included. We selected the leader/director of each of the branch programmes, the leaders of other programmes that included a mentorship module, and then at least one of the lecturers for each who linked specifically with one of the trusts included in the sample. From one HEI we included two members of the dedicated mentorship teaching team and from the other HEI a member of the dedicated placement management team and a sample of the lecturers who had a specific remit for practice-based education in one of the trusts.

Each identified participant was contacted by email with an explanation of the project and a request for their participation (n=27). The email detailed: what participation would entail; its voluntary nature and likely length of the interview; the names and roles of the research team (JC, CD, SK and SR); promises of confidentiality and anonymity; and an offer of further discussion before making a decision. Each email was accompanied by an information sheet providing further details. Non-respondents to the first email were contacted again; 24 people agreed to participate, some after requesting further information.

Once agreement to participate had been secured, arrangements were made for undertaking the interview at a time and place of the interviewee’s convenience. Consent forms, which included a request to digitally record the interview, were sent ahead of the arranged date and either returned beforehand or given to the interviewer at the start of the interview. Consideration was given to possible effects that the post held by the interviewer might have on the interviewee; this was of particular relevance to the two members of the team who held posts in a HEI and were involved in mentorship activities. The team member who led a mentorship module (SK) did not interview either of the mentorship module leaders in the study HEIs; these were undertaken by the independent healthcare researcher (CD). Team resources were such that we could not avoid some interviewees with link lecturing responsibilities being interviewed by team members who also had such responsibilities (JC and SK); care was taken to inform interviewees of the situation and for interviewers not to make assumptions about the role in institutions other than their own.

All the planned interviews took place except one; the interviewee was not present at the designated time and place and attempts to arrange the interview on another date proved unsuccessful. We were able to hold all the interviews in a room in which only the interviewer and the interviewee were present. At the start of each interview, the interviewer: made clear their own professional status and role in the research team; reminded the interviewee of the purpose of the project; asked if there were any questions arising from the information sheet; checked that the consent form had been signed; confirmed the agreement to record the interview, and re-iterated the likely length of the interview.
The interviewers followed the order of questions in the schedule but maintained flexibility when interviewees moved to a topic further ahead in the schedule. A note was made of each topic discussed to facilitate a check for completeness when the interview was drawing to a close. The interview concluded with an enquiry as to whether there were any other aspects of mentorship that the interviewee would like to discuss but had not been covered. Most of the interviews were about an hour and a quarter long although some continued for nearly two hours with the agreement of the interviewee. One interview was lost due to a technical mishap.

3.5.2 Interviewing participants in trusts
The second stage of the fieldwork, interviewing participants employed in the sample of seven trusts, included two main groups of personnel: first, senior staff identified as having a key remit for mentorship as part of an educational brief and second, practice based education support posts. In each trust, the senior person had been identified in the course of access meetings and indeed had usually been present. They held a diversity of posts and titles; deputy chief nurse (education), lead nurse for education and professional development, trust education lead, and commissioner for educational activity, thus demonstrating variation between trusts as to whom had been perceived as having the key remit for mentorship at a senior level.

Each trust in the study had at least one practice based post that focused on education; their titles included practice education facilitator, clinical placement facilitator, and practice education manager and some also had ‘senior’ in their title. In this report, this group are referred to by the most frequently used title – practice education facilitator – commonly shortened to PEF by participants. The trusts in the study varied considerably in size and geographical spread and to some extent this was reflected in the number of PEFs appointed. In one large trust with over 400 placement areas, there was a senior PEF and two others (we selected two of the three); in another trust with over a 100 placement areas spread over a wide area there were two PEFs each covering part of the area (both were selected for inclusion), whereas other trusts had one PEF only (each of whom was selected).

In total, sixteen potential trust participants were identified and emails requesting participation were sent out in October 2011. Fifteen of the 16 responded, agreeing to take part. Procedures for arranging and conducting interviews were similar to those described for the HEI participants (3.5.1).

3.5.3 The participants as a whole
Completed interviews were obtained from a total of thirty seven people (22 from the HEIs and 15 from the trusts) and comprised the following groups.

Groups of HEI participants (n=22)
The HEI participants included:

- Five senior educationalists: these were senior staff with a cross-programme remit, often entailing a strategic overview (two in one HEI and three in the other). The post-holders in this group held a diversity of titles and are referred to generically as higher education senior educationalists (HSEs) throughout the report.
• Three people who focused on the mentorship programme; the leader in both HEIs and a member of the teaching team in the HEI that had a dedicated group for this purpose. The former are denoted as MPL (mentorship programme leader) in quotations and the latter as MPT (mentorship programme teacher).

• One placement allocation officer denoted as HPAO in illustrative quotations.

• Six programme directors; they included leads for programmes which were branch specific and for a bachelor’s and a masters’ degree in nursing which included a mentorship module. This group are referred to as programme directors and denoted as HPD in the report.

• Seven staff with a link to practice of whom four were link lecturers from both HEIs and three were learning community education advisors from one HEI. This group is referred to generically as higher education practice links (HPL); this again was to preserve anonymity of the two different types of post-holders in this group.

Groups of trust participants (n=15)
The trust participants included:

• Seven senior educationalists; like their HEI counterparts they had a diversity of titles and are referred to generically as trust senior educationalists (TSEs) throughout this report to preserve anonymity.

• Eight practice education facilitators; they too had a diversity of titles and are referred to generically as PEFs throughout this report, and as TPEFs in illustrative quotations.

Nomenclature for HEIs and trusts
The design of two HEIs and a sample of the trusts with which each was linked, enabled a range of comparisons to be made between the participants in the different organisations included in the project (Section 3.6.3). They were designated as Group A which included one of the HEIs (HEI-1) and the sample of three of the trusts with which it linked (Trusts 1-3) and Group B which included the other HEI (HEI-2) and the sample of four trusts with which it linked (Trusts 4-7).

3.6 Data analysis and presentation
The digital recording of each of the 37 interviews was uploaded to the transcription agency’s website shortly after completion and verbatim transcripts returned to the team. As indicated in Section 3.1.3, the analysis of these data drew on a method known as ‘Framework’ and was undertaken by the King’s College London based researchers (JC, CD, SK and SR). The fieldwork was undertaken in two blocks of time some months apart (Section 3.5); some of the early stages of Framework were undertaken with the higher education data and then analysis of the trust data and consideration of the data set as a whole built on this preliminary work. For the purposes of this account, the stages are described for the data set as whole. The process was iterative with earlier stages being revisited and refined and with recourse back to the original transcripts; attention was paid throughout to consistency of approach and interpretation.
3.6.1 Gaining familiarity with the data

Familiarity with the material was gained in the first instance by all members of the analysis team reading a sample of transcripts representing different groups of personnel and sites. This was followed by ‘brainstorming’ sessions in which preliminary ideas were noted about key points in each of the interview sections and recurrent themes emerging across each section of the interview and across the interview as a whole. These were further refined with reading of additional interviews.

3.6.2 Identifying an analytic framework and indexing the transcripts

The process of identifying an analytic framework was undertaken by working in differing pairings of members of the research team, each pair building on and refining the work of the previous pair. Each part of the framework was allocated a code and these were applied to the transcripts. Initially we worked in pairs discussing the application of the framework to each section of text. This led to further refinement of the framework. We then coded a second group of transcripts individually and each was checked by another member of the team; this was followed by discussion about interpretation of codes and some further refinement of the framework. Once we were satisfied with the framework and confident that everyone was applying it consistently the rest of the transcripts were coded.

Some aspects of the framework were a priori topics included in the interview schedules; others were a refinement of these and a third group were new issues that emerged from the analysis. The backbone of the framework was the processes entailed in ensuring that mentorship capacity was sufficient and the views and debates associated with each of these.

Processes

The processes were the component parts of:

- ensuring that there are enough mentors and sign-off mentors
- finding and sustaining placements and allocating students
- providing education and training for mentors and sign-off mentors
- enabling the delivery of mentorship in practice
- overview processes relating to mentorship as a whole (meetings, developing materials and providing resources)

The analysis revealed the detailed and diverse processes that comprised each of the above. For each of these processes, the analysis identified: which post-holders were involved and the working relationships between them; how the process was resourced; what was seen as working well (i.e. examples of good practice); what was seen as working less well; and the personal qualities and characteristics that facilitated the process (for example -willingness to be flexible, ability to respond to diverse and changing circumstances, access to local knowledge, good working relationships, and taking responsibility).
**Views and debates**

As observed in Chapter 1, Section 1.2, organisational and individual capacity to provide mentorship are the subject of ongoing debate and several aspects of these emerged in relation to many of the processes and their components; for example should all nurses be mentors, do student numbers match placement capacity; what are the advantages and disadvantages of face to face versus online learning; how robust is the assessment of competence; and where should respective HEI and trust responsibilities lie for mentorship?

**Influencing factors**

Running through participants’ descriptions of their involvement in, and views about, mentorship were two sets of influencing factors. The first focused on quality and this included being able to meet the quality assurance frameworks entailed: in the NMC standards for mentorship; in the academic standards for HEIs; and an awareness of the impact of mentorship arrangements on standards of patient care (Chapter 1, Section 1.4). The second set of influencing factors related to the impact on capacity of current and changing circumstances in higher education and healthcare providers. These included: the extent to which mentorship was valued; changing financial climates; changes in the organisation of service delivery; mergers between healthcare providers; changes in pre-registration nurse education contracts and reviews of the role and time commitments of higher education staff.

3.6.3 Charting, mapping and interpretation

A chart was drawn up for each process, with columns for who was involved in each, working relationships across and within organisations, what worked well, what worked less well, qualities that held the process together, and the effect of influencing factors. The sections of each transcript corresponding to these was then summarised and entered into the chart. For the views/debates associated with these processes, the columns included the views held and the relevance of the influencing factors. The synthesised data enabled: analysis of the range of experience and perceptions for each process and debate and a drawing together of the range of responsibilities of each of the post-holders. It also enabled exploration of patterns in the data and where differences emerged between: Group A (HEI-1 and trusts 1-3) versus Group B (HEI-2 and trusts 4-7); trust participants versus HEI participants; and between different groups of post-holders. The sampling strategy enabled analysis of differences between trusts in that the experiences and views of those relating to a specific trust could be considered in conjunction (i.e. the trust senior educationalist, the trust PEF and the HEI practice link). All the data obtained were analysed and are all included in the presentation.

3.6.4 Presenting findings

Various options were considered as how best to present the findings. Drawing on a discussion by Coffey and Atkinson (1996) the decision reflected what we felt was most important to convey, namely the processes and the views/debates associated with each. The first chapter of findings (4) focuses on the components of the hinterland to mentorship and which were relevant to all the processes identified: namely the links between organisations; the post-holders and their areas of responsibility; and resourcing mentorship through meetings, developing materials and providing and accessing resources. The following chapters each focus on one of the project objectives and the processes and associated views/debates which it comprised: providing mentors and sign-off mentors
in Chapter 5, finding placements and allocating students in Chapter 6, providing education and
training for mentors and sign-off mentors in Chapter 7 and delivering mentorship in practice in
Chapter 8.

Findings are presented by the groupings that emerged as appropriate from the analysis (Section
3.6.3). The process of charting the data indicated the number of participants who had provided a
response for each question as well as the number expressing certain views; this information is
included in the account to demonstrate the extent to which the conclusions are founded on the data
set as a whole. Given the wide range of issues considered in the project, each chapter section is
concluded with a summary of key points and each chapter as whole with some overview
observations.

3.7 Generalisability of findings

In considering the generalisability of the findings, we drew on what Lewis and Ritchie (2003) refer to
as representational generalisation. As these authors observe, much qualitative research takes place
in one or two settings and the approach to generalisation is often described as naturalistic (a
concept developed by Stake 1978). This requires researchers to provide sufficient detail and
interpretation, as well as connecting the particularity of the case to the wider context, in order that
others can assess the transferability to different or similar contexts.

In this research, the sites were purposively selected to represent the diversity of higher education
and healthcare providers in which the delivery of mentorship is situated. Within these sites, the key
personnel were then identified and included. It is the content or ‘map of the range of views,
experiences, outcomes or other phenomena under study, and the factors and circumstances that
shape and influence them that can be inferred to the researched population’ (Lewis and Ritchie
2003,p.269). In Chapter 9, we consider how the findings reported here, which are London-based,
might illuminate the issue of mentorship generally.
Chapter 4: Mentorship capacity: roles, resources and organisations

This first chapter of findings sets out the components of the mentorship hinterland concerned with roles, resources and organisations. This provides the context for the various aspects of mentorship capacity explored in subsequent chapters: providing mentors and sign-off mentors (Chapter 5); finding placements and allocating students (Chapter 6); educating mentors and sign-off mentors (Chapter 7); and delivering mentorship in practice (Chapter 8).

Section 4.1 provides an introduction to the nine organisations included in the project, the titles and roles of the 37 participants selected from these organisations and the model adopted by the two HEIs for providing the mentorship course for staff in healthcare providers. This introduction sets the scene for participants’ descriptions of the current and changing links between their organisations (4.2) and of their own role and responsibilities for mentorship as trust staff (4.3) and higher education staff (4.4). The next three sections each focus on an aspect of resourcing mentorship: formal and informal mechanisms for these groups of staff to review progress and decide on strategies for mentorship in their organisations (4.5); the development of websites and materials to support mentorship (4.6); and funding, study leave and time to enable mentorship to be provided (4.7). Observations on the findings as a whole are drawn together in Section 4.8.

4.1 Organisations, post-holders and education for mentorship

Organisations

Both of the HEIs had a faculty providing education for health and social care professionals with nursing being one of the largest groups. HEI-1 was based in a suburban location and was associated with healthcare providers in a wide geographical area encompassing suburban, rural and inner city locations and a diversity of practice settings. HEI-2 on the other hand was based in an inner city location and the healthcare providers with which it was associated were spread over a smaller area but still encompassing a diversity of locations. Each HEI was associated with many healthcare providers ranging from large hospitals to community clinics and nursing homes; a sample was drawn for each HEI that included an acute and general services trust, a primary care trust and a mental health trust with a fourth trust that included a specialist hospital also selected for one of the HEIs (Chapter 3, Section 3.2.2).

Post-holders

The 37 participants were purposively selected in light of the remit for mentorship encompassed within their role and responsibilities. The rationale for selecting those included was provided in detail in Chapter 3, Section 3.2.2. In each of the seven trusts, the senior member of staff with an educational brief that encompassed mentorship was included; they had a diversity of titles and remits and are referred to generically as trust senior educationalists throughout the report (TSEs). The second group of trust personnel were the practice education facilitators (n=8); these posts had been funded by the Strategic Health Authority as part of a strategy to enhance the quality of the learning environment in practice areas. They also had a diversity of titles and are referred to generically as practice education facilitators (PEFs) throughout the report and as TPEF in illustrative quotations.
For the purposes of considering responsibilities for mentorship, the higher education participants were considered as five groups. The first group were senior staff with a cross programme remit, often entailing a strategic overview (n=5, two in one HEI and three in the other). The five post-holders in this group had a diversity of titles and varying remits for pre and/or post registration education and some had posts with a specific focus on practice-based education. As with the senior educationalists in trusts, they have been given a generic title, higher education senior educationalists and are denoted as HSE in this report. The second group were those whose primary remit was the mentorship programme; the leader from each HEI (denoted as MPL in quotations) and a member of the dedicated teaching team in HEI-2 (MPT). Programme directors/leads comprised the third group (n=6) and included four leads for branch programmes and two leads for a bachelor’s and master’s nursing course respectively that included a mentorship module; they are referred to as programme directors and denoted as HPD in quotations. The fourth and largest group all had links to practice and included four lecturers/senior lecturers and three learning community education advisors (LCEAs); they are referred to generically as higher education practice links (HPL in quotations) and when appropriate a distinction is made between those who were link lecturers and those who were LCEAs. The fifth group, just one individual, was a placement allocations officer, denoted as HPAO in the report.

**Education for mentors: courses and professional updating**

One of the criteria for selecting the two HEIs was that each had adopted a different model for providing mentorship courses for staff in their associated healthcare providers. Both HEIs had appointed an overall mentorship programme leader. In HEI-1, people teaching on the course in addition to the programme leader were either lecturers who taught on one of the programmes and had a practice link role or staff who held one of the learning community education advisor posts. Teaching on the mentorship course was thus just one of the responsibilities of this group of staff. In HEI-2, mentorship courses were provided under the auspices of an education unit which oversaw the provision of mentorship modules; these were taught by a team appointed with this specific remit, not all of whom were nurses and, apart from the mentorship programme leader, none were link lecturers.

In both HEIs, the mentorship course could be taken as a stand alone module or as a module that was part of an undergraduate or postgraduate degree and both offered versions which were a blend of face to face teaching and on-line provision as well as an on-line version only (further details are in Chapter 7, Section 7.1). The remit of trust and HEI post-holders included ongoing education for mentors in the form of annual updates and triennial reviews and providing additional preparation for those who wished to be recognised as sign-off mentors (Sections 4.3 and 4.4).

**4.2 Current and changing links between organisations**

For the purposes of providing experience for pre-registration nursing students, the healthcare providers (NHS and primary care trusts and independent sector providers) associated with each HEI were grouped into what participants in one HEI referred to as ‘communities of practice’ and participants in the other as ‘learning communities’. These are referred to collectively as ‘learning communities of practice’ throughout this report. Pre-registration students were allocated to one of these communities at the start of their course and in the main remained in this community for its duration; in the words of one of the PEFs:
Within each community, the students were allocated to practice settings to provide the requisite experience for each year. The mentors with whom they were paired had taken an HEI mentorship course; if this was while employed in their current trust, then most likely at the HEI with which the trust was associated. Members of the HEI staff with link lecturing responsibilities were each allocated to practice areas within one of these communities.

At one time, links between HEIs and healthcare providers tended to be stable over long periods of time; more recently, however, both types of organisation have had greater freedom to change links and this, combined with a period of change in education and healthcare has led to a much more flexible situation and, to some extent, one characterised by increasing uncertainty. Participants were asked for details of the organisation(s) with which their own linked and whether they were aware of any proposed changes. The HEI participants were also asked if their HEI was the main one with which their associated healthcare providers linked while trust participants were asked to specify the main HEI with which their trust linked and whether there were any additional links with other HEIs. Findings are presented for each HEI and its associated sample of trusts.

4.2.1 Group A (HEI-1 and trusts 1-3): participants’ observations on links between organisations

**HEI-1 participants’ observations on links**

As expected, the placement allocation officer at HEI-1 had all the details to hand of the large number of trusts (hospital, primary care and mental health) and independent providers with which this HEI linked. The mentorship programme leader was able to cite most of these providers since her role included liaising with them about allocating staff to places on the HEI mentorship course, but hesitated over a couple of the primary care trusts commenting that they changed their names so often. Of the two senior staff in this HEI, the one with a more practice focused brief could cite all the providers whereas the other commented ‘I could do a few but I don’t think I could do all of them’. Both the programme leads in this HEI were conversant with all the providers and provided details of the various settings within which students from their branch were placed.

The other HEI participants, who each had a link to practice, covered the following healthcare providers between them: a hospital trust providing acute and general services, a primary care trust, a mental health trust, community services spread across a wide area, and services provided by the independent sector, primarily in the form of nursing care homes. They each provided very specific details of the areas to which they related personally but varied in the extent of their knowledge about the other providers. All participants said that their HEI was the main educational link for their healthcare providers and had varying degrees of knowledge about the links that some of these providers also had with one or more other HEIs.

When asked if there were any plans to change the healthcare providers with which the HEI was linked, the question was interpreted in two ways: whether the HEI itself was making active plans to change the providers with whom it linked (n=10) and/or whether changes might be the result of developments among healthcare providers themselves (n=5). In relation to the HEI making plans to change, five participants said that there were no plans to do so and five expressed uncertainty on this point. Changes occasioned by developments among healthcare providers included mergers.
between trusts, decisions not to continue the contract with the HEI, and changes in service provision. Participants’ observations about the impact of these changes on placement provision are detailed in Chapter 6, Section 6.5.2.

**Trusts 1-3 participants’ observations on links**

Links between organisations and potential changes appeared to be a less complex matter for the Group A trust participants than for their HEI colleagues. Trust 1 (primary care) had links with another HEI as well as HEI-1; the senior educationalist said:

“we have a really sound working relationship with both of them. There are no plans to change at the moment as far as I’m aware.” (TSE1)

The PEF referred to a recent merger of the primary care trust with other trusts and that she was already developing working relationships with the placement facilitators and educationalists within these trusts.

The senior educationalist and the PEF in trust 2 (acute and general services) both said that they linked only with HEI-1 and that there were no plans to change this, although the former also observed that changes might be occasioned by the outcome of a new cycle of commissioning by the Strategic Health Authority. Links were more diverse in trust 3 (mental health); the senior educationalist and the PEF both said that they linked with HEI-1 for mentoring pre-registration students and with HEI-1 and two other HEIs when commissioning places for staff to attend a mentorship course. The trust had recently merged with two others and the senior educationalist perceived this as a positive development for pre-registration nursing in terms of both increasing the number of students who could now be accommodated and the range of services in which they could be offered experience.

**4.2.2 Group B (HEI-2 and trusts 4-7): participants’ observations on links between organisations**

**HEI-2 participants’ observations on links**

HEI-2 was associated with fewer trusts than HEI-1 and these were spread over a smaller geographical area. Like HEI-1, it linked with a range of providers in the independent sector and these included a large number of nursing care homes as well as independent hospitals. Among the senior educationalists, the person whose post had a practice focused remit was able to provide details of all the providers with the others having most of the detail of the larger trusts to hand. Of the other HEI participants, only the mentorship teacher recalled the names of all the trusts with the others either citing fewer or acknowledging that the names of some trusts ‘escaped them’. As with HEI-1, the participants who linked with practice covered a diverse range of services between them and each provided details of the various settings in the trust or areas to which their link lecturing responsibilities related. Most said that their HEI was the main link for all the healthcare providers, with a few referring to the one provider whose main link was with another HEI.

When asked if there were any plans to change the healthcare providers with which the HEI was linked, the HEI-2 participants, like their counterparts in HEI-1, interpreted the question in two ways; referring to the university making plans (n=8) and to changes occasioned by trust developments (n=8). In relation to plans being made by the university, four expressed uncertainty about whether
the HEI had plans to make changes, three that there were no such plans and one that the HEI was already developing relationships with new trusts as well as intending to keep their current links with their main provider.

In relation to changes being driven by trust developments, as one of the programme heads put it:

“I think it’s more a case of do they want to change with us rather than we want to change with them.” (HPD3)

Participants referring to trust developments spoke with varying degrees of certainty about what was being proposed. Some of the likely mergers were known to be between trusts that linked with different HEIs and so negotiations would be needed over access to placements for students. For one of the programme heads, this was already a source of concern:

“There are whispers and rumours of amalgamations, split offs and that could potentially decrease our capacity. I think we would like to hang on to the trusts we have got big time but I think we are going to see other HEI providers chiselling in the background.” (HPD3)

One participant thought that mergers between trusts could affect the current boundaries of the learning communities of practice. Overall there was a sense of uncertainty about the future; as one link lecturer said:

“…there’s so much potential change in the air, how it will all pan out I’m not sure.” (HPL7)

**Trusts 4-7 participants’ observations on links**

The senior educationalist in each of the four trusts associated with HEI-2 said that this was the only HEI with which they were linked for mentorship purposes and that there were no plans to change this link; two added that current working relationships were good. However, these senior educationalists and the PEFs who worked with them were all aware that changes might be inevitable, with four referring to the potential impact on their current HEI link of recent tendering processes and three to the impact of trust mergers.

Trust 4 (primary care) was in the process of merging with another and additional mergers were under discussion. This combined with NHS London’s call for all universities to re tender for pre-registration nursing contracts, led the PEF to say:

“…so at present everything is very uncertain and we don’t know what is going to happen.” (TPEF4)

Trust 5 (specialist and general services) was in the process of merging with another that linked to a different HEI and this, combined with the possibility that both HEIs might lose their contract to provide pre-registration nurse education, might result in changes in their future academic links. A similar situation of uncertainty prevailed in Trust 6 (acute and general services); the senior educationalist and the PEF both said that decisions about who they linked with in future would be decided by the senior person in the merged trust. In the words of the PEF:

“I presume people that get the key roles will then maybe make decisions. Obviously the tendering is something that could affect the commissions and business plans in the future and also the fact
that there is less money around...Yeah, so there’s quite a lot of uncertainty...everyone is ‘business as usual’, but nobody is quite sure.” (TPEF6)

Uncertainty over the outcome of tendering was the main concern for the two PEFs in Trust 7 (mental health). The issue here was that if HEI-2 did not succeed in securing the tender for the adult branch programme then it might not be viable for it to provide the mental health branch programme. Moreover, there were rumours about plans that the Strategic Health Authority might have for mental health nurse training across the capital as a whole; as one of the PEFs said:

“We’ve asked, but nobody seems to have a definitive answer.” (TPEF7)

4.2.3 Key points on links between organisations

- A complex and changing picture emerged from participants’ accounts of links between their own and other organisations.
- HEI participants had varying degrees of certainty about current links and proposed changes, depending to some extent on their own role within the organisation.
- Trust participants were certain about the one or at most two or three HEIs with which their trust linked and, as with the HEI participants, had varying degrees of certainty about proposed changes.
- It is within this context of complexity and potential uncertainty that trust and HEI participants were undertaking their responsibilities in relation to mentorship.

4.3 Roles and responsibilities for mentorship of trust post-holders

As detailed in Section 4.1, the trust-based participants in the study comprised two main groups; the eight practice education facilitators (4.3.1) and the seven senior nurses with a remit for education that included mentorship (4.3.2).

4.3.1 Trust-based practice education posts: roles and responsibilities

Each trust in the study had at least one practice-based post that focused on education, referred to as practice education facilitators (PEFs) in this report. The eight PEFs were asked about the responsibilities involved in their post and for their views on many aspects of mentorship. This section provides an overview of their remit for mentorship.

Prior to taking up post they had had substantial clinical and educational experience and, as one of them put it:

“My background is clinical for a long time...So I was a mentor, and I’ve been a student a lot of times myself. So I feel that it gives me some insight into the role.” (TPEF 4)

The PEFs were line managed by a senior nurse in the trust with an educational remit and, in most instances, the one whom we interviewed. As well as their line manager, the PEFs’ working relationships with colleagues in their trust included managers of practice settings, mentors and other clinical staff and in some cases a placement allocations officer. Their main working relationship with staff based in the HEI with which their trust was linked was with the link lecturers.
and also the placement allocations officer for those in trusts linked with HEI-1. In the course of their work, PEFs attended a range of committees and working groups (detailed in Section 4.5) at which they met with trust colleagues and/or with HEI staff involved in the mentorship module and the pre-registration branch programmes. Some of these meetings also provided opportunities to meet with PEFs from other trusts associated with the same HEI. The PEF’s role thus entailed working with a network of colleagues across the trust and the HEI.

The essence of the PEF’s role was ensuring the quality of the learning environment and taking action to ensure that this was maintained; two of the PEFs expressed it thus:

“*My role is to quality enhance and ensure the practice placement experience for students. To ensure that all our mentors meet the NMC standards.*” (TPEF6)

“*Part of our role is always keeping a lookout for whether or not that quality is sustained in a placement, and where it’s not we need to act to ensure that the students get a valuable experience wherever they go.*” (TPEF 8)

In ensuring this quality, the interviews with PEFs revealed the diversity of activities that this entailed; these included specific tasks such as keeping the register of mentors up to date and running workshops to prepare sign-off mentors as well as ongoing work in ensuring sufficient mentors in each setting and then supporting these mentors and their students. But their role also required a less tangible quality – the detailed knowledge of their ‘patch’; described in the words of one PEF:

“I see mentorship not as isolated but integrated with everything else. *My role is very much operations based - so checklists of things like mentor updates. But also knowledge of what is going on in the clinical areas, what is happening to staff, to teams and to services which enables me to support mentors and students in a better way.*” (TPEF1)

The responsibilities that PEFs described were grouped together as follows: ensuring capacity for mentorship; providing education for mentors; supporting delivery in practice; and developing materials and systems.

**Capacity for mentorship**

All the PEFs described their role in ensuring that placement and mentor capacity was sufficient to meet the needs of the HEI with which they linked. This included finding placements for the students allocated to the trust and in some instances working with an allocations manager (trust or HEI based) who decided broadly where students would go, with the PEF then making the detailed decision based on their knowledge of the current situation in each practice setting. Others were responsible for both the broad and the detailed level of decision-making. The number of staff in a practice setting able to mentor students was critical to whether the setting could be included in the placement circuit and all the PEFs said that ensuring that there were enough mentors was a central part of their role. The register of active mentors was integral to assessing the ongoing capacity of placements to support students and ensuring that it was kept up to date fell within the responsibilities of each of the PEFs in the project.
Education of mentors - teaching on the course
None of the PEFs were currently involved in teaching on the mentorship course based in the HEI, although some reported involvement in developing its content in their capacity as members of a mentorship programme board. As part of their remit for supporting mentors, some PEFs specifically referred to supporting staff who were on the course by, for example, making sure that they were allocated a student for the practice-based component of the course.

Education of mentors – professional updating and sign-off mentor preparation
All the PEFs were involved in undertaking annual updating of mentors; one of the purposes of the mentor register was to indicate when each mentor had completed an update and hence the date when the next one was due. A varied approach to annual updates was evident; and included sole provision by PEFs, joint provision with link lecturers, face to face sessions and updating through written materials when the nature of the trust meant that mentors were widely dispersed. The trusts were at different stages in introducing sign-off mentors and hence sign-off mentor preparation. From the PEFs’ perspective, most were involved in providing sign-off mentor workshops, often in conjunction with link lecturers. Triennial reviews were also at fairly early stage in most trusts and so the PEFs’ involvement was fairly limited at the time of the fieldwork.

Supporting delivery of mentorship in practice:
For all the PEFs, supporting the delivery of mentorship in practice was a key part of their role. Most of the PEFs provided induction sessions for students at the start of their course and in some trusts in their second and third years as well. They made sure that mentors could always contact them and so they could respond quickly when problems between a mentor and student needed resolving; for example over personality clashes or issues about student progress. All the PEFs had a role in auditing placements but the nature of their involvement varied depending on the input of link lecturers and trust-based staff such as ward managers and key mentors.

Developing materials and systems:
All the PEFs were involved in developing materials to support mentorship and as subsequent sections (4.6) and chapters will show, these included student induction packs, competency portfolios, and records for mentoring activities; sometimes this work was undertaken with other PEFs linked to the HEI but more often in collaboration with HEI colleagues. Some PEFs also described particular initiatives which they had implemented in response to a perceived lack in their trust; examples included a review of mentor strategy best practice guidelines and a new system to ensure that mentor updates were done every year.

4.3.2 Trust-based senior education posts: roles and responsibilities
Senior staff in the trusts identified as having a key remit for mentorship as part of an educational brief are referred to generically as trust senior educationalists (TSEs). Their precise roles and responsibilities in relation to mentorship varied from one to another but all described commissioning mentorship courses, most described themselves as having overall responsibility for mentorship and for assuring its quality, many aspects of which were undertaken on a day-to-day basis by the practice education facilitators (PEFs); and most emphasised the strategic nature of their roles in ensuring the quality of, and capacity for, nursing education. Most of the group were
responsible for line managing the PEF(s); their own line manager varied considerably from one trust to another.

**Commissioning mentorship courses**

The trust senior educationalists were responsible for ensuring that there were enough mentors to support the pre-registration students by commissioning places on the mentorship course in the HEI(s) with which their trust linked. The number commissioned depended on information obtained in the course of a training needs analysis for each of the practice settings in the trust, an analysis that was undertaken in consultation with PEFs and/or clinical managers. Commissioning places and dealing with matters arising, such as the availability of spare places at short notice, involved close liaison with the relevant HEI personnel, most likely a contracts manager and/or commissioning coordinator. For one TSE, recent organisational changes had meant that it had become much more difficult to obtain timely information from HEI personnel. For some of the group, their commissioning role also included negotiating with staff and their managers about ensuring that the staff member was given their requisite study leave and at a time that suited both the staff member and the manager.

**Quality assurance for mentorship**

The TSEs described their role as one of having overall, or in some instances, ultimate responsibility for the quality of mentorship. This involved ensuring that the PEFs had all the information and support that they required to perform their role and were able to access senior nurses in the organisation if they needed to discuss mentorship issues at that level. The TSEs became involved in discussions when there were issues to be resolved and then ensured that decisions and accompanying documentation went to the relevant professional/executive board in the trust. Such issues included the capacity of placements to take the allocated number of students, dealing with student complaints and assessing whether a placement area should be removed from the education circuit. Several of this group said that they had ultimate accountability for ensuring that the mentor register was kept up to date.

**Having a strategic overview:**

In ensuring the quality of nursing education, most TSEs emphasised the strategic nature of their role. This entailed regular liaison with senior staff in the HEI, such as the overall lead for the pre-registration programme and attending meetings on, for example, placement review and curriculum development. One stressed the importance of her role in ensuring that all the regulatory support required for mentorship was in place in preparation for visits from the NMC. Some described other groups with which they were involved which had a wider strategic remit, such as the senior heads of nursing group, to inform their own thinking about the quality of education.

In the words of one of the group:

"I think education and quality are completely linked – it’s the essence of my role. It might drive me to distraction sometimes in terms of marrying the two up on a higher level and activity, but if I think about why education sits with government it’s because we educate our workforce to be able to provide safe care and quality care." (TSE4)
4.3.3 Key points on roles and responsibilities for mentorship of trust based posts

- Trust based staff were involved with diverse aspects of mentorship.

- The PEFs’ role appeared central to many aspects of mentorship in practice and they drew on a network of relationships and resources across the trust and the HEI.

- PEFs’ brief included: finding placements, ensuring that each had enough mentors, allocating students to mentors, contributing to the content of the mentorship module, supporting mentorship students during the practical component of the course, undertaking annual updates for mentors, providing sign-off mentor training, supporting qualified mentors and students in practice, auditing placements, and developing materials to support mentorship.

- PEFs regarded their detailed knowledge of the practice settings within their trust as key to the deployment of their responsibilities.

- PEFs had close working relationships with the senior educationalist in the trust who, most often, was their line manager and provided information upon which the senior educationalist could make decisions.

- The role of senior educationalists, apart from specific tasks such as commissioning courses, was an overall responsibility for the quality of mentorship in their organisation and having wider strategic perspectives necessary to ensure this quality.

- Subsequent chapters show how the roles and responsibilities of these two trust-based groups of staff were deployed in implementing the various processes that underpin the delivery of mentorship, how these interfaced with those of their HEI counterparts, the challenges that they faced and their views on some of the key debates and questions that currently characterise the provision of mentorship for student nurses.

4.4 Roles and responsibilities of higher education post-holders

The higher education-based participants comprised five main groups (Section 4.1) and this section focuses on the roles and responsibilities of each: mentorship programme posts (4.4.1); the placement allocation officer (4.4.2); the programme directors/leads and the personnel with practice links (discussed jointly in 4.4.3) and a group of staff with a cross-programme remit, often entailing a strategic overview (4.4.4). Some of the responsibilities for mentorship held by HEI personnel were specific to one of these groups whereas others were the remit of two or more groups. These cross-post responsibilities are drawn together in Section 4.5.

4.4.1 HEI-based mentorship programme posts: roles and responsibilities

The HEI-based mentorship programme posts included one of the dedicated mentorship team teachers in HEI-2 and the programme leaders in both HEIs. The mentorship programme teacher led a level 6 module and like several other members of the team was not a nurse but had obtained the post on the basis of other experience. The role was described as entailing: teaching, marking, moderating, attending assessment boards and participation in programme management team meetings on teaching and curriculum design. The post did not require any involvement in mentorship in the trusts in terms of placement and mentor capacity and professional updating:
“I’m not quite sure what happens in trusts – I’m not sure of who works at what level. I don’t have anything to do with that side of things.” (MPT1)

The remit of the mentorship programme leader in each of the HEIs included: responsibility for developing the content of the module; managing its administration; and supporting the mentorship teaching team. The process of curriculum development entailed drawing together work undertaken by subgroups of team members, each working on the content and associated practical experience to be included in one of the module themes. The HEI-1 programme leader was also responsible for turning the module into an on-line format. Both described a role in ensuring that capacity on the taught and on-line courses met the number of places commissioned by the trust and this entailed liaison with the HEI contracts manager. The HEI-2 programme leader added that although she did not have a formal role in commissioning courses, she had gone out to meet staff in other healthcare providers, not yet associated with the HEI, but who had expressed an interest in attending the course. Neither programme leader was involved in placement management. The administration involved in managing the courses was considerable, given the number of modules running at any one time (five in the case of HEI-2) and the large numbers of students coming onto the courses every year (over 800 in the case of HEI-1).

Both programme leaders said that they had chosen to apply for the role, rather than having been requested to take it on, and that their previous experience of mentorship had been preparation for the responsibilities of the post. The HEI-1 programme leader had long experience of running mentorship updates courses and had assisted a trust in developing a mentorship programme; this experience combined with her interest in blended learning (a mix of face to face and on-line sessions) had underpinned her decision to apply for the position. The programme leader in HEI-2 likewise had long experience of mentorship and described wanting to take on the challenge of running a course that she perceived to be unpopular and often not enjoyed. Both programme leaders were line managed by a senior educationalist in their HEI. They each described working closely with their teaching team and met regularly to discuss and review progress; a point corroborated by the team members themselves. The HEI-1 programme leader described close links with the field lead for each programme/branch and the lead link lecturer for each healthcare provider and worked jointly with these personnel to resolve any problems with students on the course. Both programme leaders had responsibilities as link lecturers, fairly recently assumed by one of the two.

The programme directors who led a bachelor’s and a master’s course in nursing in HEI-2, both had responsibility for the mentorship module that was included in the portfolio of modules of which their courses were comprised. These mentorship modules came under the overall administration of the mentorship programme leader. Neither programme lead taught on the module. The lead for the bachelor’s programme was responsible for assessing the mentorship module and the lead for the masters’ programme had a remit for: encouraging students to take the module; ensuring that the number of places available met trust requirements; and ensuring that course content met academic standards and was practically relevant to the needs of students and employers.
4.4.2 HEI-based placement allocation officers: roles and responsibilities

Advance planning was necessary to decide which placements each cohort of students would be allocated to throughout the duration of each of the years of their programme. In HEI-1, this process was undertaken for the pre-registration student population as a whole by a dedicated team of staff employed by and based in the HEI. In HEI-2, the process of allocation had traditionally been undertaken within each learning community of practice, but a new person had recently been appointed to the HEI with responsibility for allocating all the students to placements throughout their programme.

The HEI-1 placement allocation manager described the role as one of heading up the administration of the placement allocation team and managing and organising the administration of placements. Six placements per student for each of the three years of the programme had to be planned and mapped in advance but the allocation could not be too prescriptive as the plan had to be sufficiently flexible to accommodate changes in placement availability and suitability. The post holder was thus in regular contact with trust-based practice education facilitators and with HEI staff with links to practice areas to respond to changing circumstances. The responsibilities of the post did not include direct involvement in finding placements or monitoring their quality. Neither the post-holder nor the members of the team were nurses, rather they were all administrators and had been offered the post by a senior member of the faculty on the grounds that having non nurses in these posts would mean a greater emphasis on the academic aspects of placements and programmes since they could not be asked to deal with practice issues.

4.4.3 HEI-based posts for specific programme and/or practice areas: roles and responsibilities

Two groups of the HEI-based posts, the programme directors/leads (n=6) and the staff with practice links (n=7) had responsibilities relating to specific programmes and/or practice areas.

The programme directors/leads

This group included four people who led a branch specific programme, the lead for a bachelor’s degree in nursing and the lead for a master’s degree in nursing. As noted above, the two latter people were responsible for the mentorship module included within their course. All six described their responsibilities for the overall management of their programme with some also referring to programme validation and assessment responsibilities. Four of the group were also link lecturers. The programme leader (adult branch) who was not a link lecturer described working with a team of link lecturers for the adult programme for NHS trusts and the independent sector and having the responsibility of ensuring:

“That it is all in place and that the environment is suitable for our students.” (HPD1)

None of them were currently leading a learning community of practice or were involved in teaching on the mentorship course, although one had done so until recently. They were usually line managed by one of the senior staff with a strategic cross-programme brief.

Lecturers/senior lecturers and learning community education advisors

The four lecturers/senior lecturers each taught on one of the three branches and were responsible for one or more practice settings within that branch (i.e. were link lecturers). Two of the link lecturers also taught on the mentorship course and two held positions as the academic lead for one
of the learning communities of practice. The lecturers were usually line managed by the head of the programme on which they taught. Three people included in this group had been appointed to a relatively new post introduced and funded at HEI-1 and entitled ‘learning community education advisor’ (LCEA). The three LCEAs were members of the HEI-based Practice Education Support Unit and each was the lead education link for practice areas in one of the learning communities of practice. One focused on adult nursing within a large hospital trust, a second on primary care trusts and the third on mental health practice settings. They did not teach on the HEI undergraduate programmes but did teach on the mentorship course. Their role was much more practice focused than that of the other HEI staff, as one of them put it:

“Well obviously one of our biggest challenges is to make sure that the standards to support learning and assessment are being met in the trusts that I am learning community education advisor for. So that’s really my responsibility.” (HPL2)

**Responsibilities and working relationships of programme directors, link lecturers and LCEAs**

In the course of fulfilling their responsibilities for mentorship, the programme directors, lecturers and LCEAs liaised with a wide range of trust personnel (mentors, students, PEFs, managers in practice settings and more senior managers depending on their own level of seniority). As well as informal contacts, they met with these trust colleagues and other HEI personnel in a range of meetings to discuss and review the progress of various aspects of mentorship (Section 4.5) and some were involved in the development of materials (Section 4.6). Responsibilities for capacity could include: opening up and developing new areas for placements; checking on the mentor register to see where shortages exist; liaising with trust staff over how many students practice areas could support, and auditing placements.

Those who had a link with practice as link lecturers or LCEAs provided support for students and mentors. This support could include: liaising with the setting manager; having one-to-one sessions with students; one-to-one sessions with mentors, sometimes in the format of an annual update; and meetings with both together particularly when there was a problem to be resolved. This support was undertaken either by phone or face to face; for some personnel, the latter entailed visiting many different sites particularly those who linked with primary care trusts and with the independent sector. Other aspects of their role included leading or participating in the preparation of sign-off mentors.

For those who were link lecturers, the allocation of time between the academic and practical components of their role varied by staff and, as subsequent chapters show, was sometimes a subject of concern. For all three of the LCEAs, the quality of their working relationships with practice based trust colleagues was key to the fulfilment of their role:

“I can walk into any of my practice areas and I know them all by name and they all know me, and half of them have been ex students...there’s no... and everybody knows who I am and knows how to contact me...we have very, very friendly relationships with each other.” (HPL2)

Close working relationships with a senior trust post-holder were also cited; for one LCEA this was the lead education link with whom she met once a month to discuss mentorship issues. In addition, they
kept regularly in touch and met to update the mentors’ register and provide joint training sessions for sign-off mentors:

“If there’s a problem with a student then I refer that back. I deal with it but I let them know what I’ve been doing. It’s partnership working very much at its best, I think.” (HPL1)

4.4.4 HEI-based posts with a strategic, cross-programme remit: roles and responsibilities

Five of the HEI participants had a strategic remit for education that was not programme specific. One member of the group focused on post-registration education, three on pre-registration education and one on both. Two of them held a post that had a specific brief for the quality of practice education. The participant with a brief for post-registration education was responsible for: ensuring the quality of the programmes, including the one that delivered the mentorship module; acting as the contract lead in the HEI for trusts when they bid for post-registration places; liaising with the trusts’ educational leads; examining trust mentor registers; and making sure that all necessary preparations were made for reviews by the Nursing and Midwifery Council. Until recently, the post-holder’s responsibilities had also included teaching on the mentorship module.

Descriptions of the roles of the other four participants in this group revealed differing briefs but all had a strategic responsibility for mentorship without direct involvement in the processes themselves. Strategic responsibilities included some or all of the following: chairing or membership of the main HEI-based strategic meeting for managing mentorship (Section 4.5); managing the people who were directly responsible for aspects of mentorship; liaising with senior colleagues in trusts about practice education matters, such as the number of students to be supported and feeding this back to the HEI; ensuring that the mentor databases were up to date and that there were enough mentors; and preparing for validation visits by the NMC. The latter included making sure that staff who would be involved in making presentations to the visiting NMC team were properly prepared to do so.

Direct involvement in mentorship was only occasioned by, for example, problems over placement capacity and this involved negotiating with trust education leads to take more or less students when the commission did not match capacity. One of the two with a practice-focused brief described being part of the team that developed the mentorship module and ongoing awareness of whether there were any changes in trust commissioning of post-registration courses that might need action. The other described involvement in a pan-London working group developing a tool for placement assessment.

4.4.5 Aspects of mentorship undertaken by two or more of HEI-based post-holders

The role and responsibilities of the two groups of trust-based post-holders (Sections 4.3.1 and 4.3.2) were separate albeit linked in some respects. However, for the HEI-based post-holders, the above account has shown that there were several aspects of mentorship that were included in the remit of at least two or more of the groups. In order of frequency these were: matters concerning availability of placements and having sufficient numbers of mentors (n=17); supporting the delivery of mentorship in practice (n=14), providing education for mentors in the form of professional updating and/or sign-off mentor preparation (n=13), developing materials and systems (n=11), teaching on the mentorship course (n=8) and having a lead role in a learning community of practice (n=5). The
centrality of each of these aspects of mentorship to the role of each participant depended on the specific remit of their post and their other responsibilities.

4.4.6 Key points on roles and responsibilities of HEI-based post-holders for mentorship

- HEI-based post-holders were involved in diverse aspects of mentorship, some specific to HEI post-holders, others had similarities to those of trust post-holders.

- Specific aspects included planning placement allocation and managing and teaching the mentorship programme courses. Aspects involving both HEI and trust post-holders included: finding placements, ensuring that each had enough mentors, contributing to the content of the mentorship module, supporting mentorship students during the course, undertaking annual updates for mentors, providing sign-off mentor training, supporting qualified mentors and students in practice, auditing placements, and developing materials to support mentorship.

- HEI senior educationalists had overall responsibility for the quality of mentorship in their organisation and for its strategic direction.

- Subsequent chapters show how the roles of HEI post-holders were deployed in the various processes that comprise mentorship, the way in which their responsibilities for each were complementary or otherwise to those of their trust counterparts, the challenges they faced and their views on some of the key debates and questions that currently characterise the provision of mentorship for student nurses.

4.5 Resourcing mentorship: discussions, planning and decision-making

The next three sections consider aspects of resourcing mentorship with this first one focusing on the various meetings (committees, forums, working groups etc) at which participants discussed, planned and made decisions about mentorship strategies and activities. These meetings varied considerably in terms of formality, frequency and personnel attending and included: HEI-based meetings for all the key groups involved in mentorship; meetings of people with a specific remit (teaching on the mentorship module; working as a PEF; placement management; strategic liaison, and programme development and assessment); practice-based meetings (members of a learning community of practice, key mentors); and special interest meetings. Although the details of these various meetings differed between the HEIs and their partner providers; the key purposes were similar.

4.5.1 Strategy meeting for managing mentorship

Most participants referred to an HEI-based committee, attended by representatives of all the key groups of HEI and healthcare personnel involved in mentorship, other than the mentors themselves, and which was described as the major forum for managing mentorship at a strategic level. The committee’s remit was the quality of all aspects of mentorship, some of which were subsequently taken forward in smaller working groups. In both HEIs, the committee was chaired by a senior educationalist with a practice-focused remit. There was some inconsistency in participants’ responses as to the title of the committee with practice featuring in all variations, and in the frequency of meetings with twice a year featuring most often at one HEI and bi-monthly at the other.
From the HEI side, attendees included the HEI senior educationalists, programme leaders, placement officers, leads for the learning communities of practice and other lecturers with a link to practice. Some said that they tried to attend whenever possible but overlapping commitments meant that this was not always possible. From the healthcare provider side, the PEFs always attended but the senior educationalists usually did so only if there was an issue of particular concern. One of the latter spoke of issues that arose at meetings that s/he attended but the PEF did not and then they raised it jointly at the strategy meeting. And another referred going to support the trust PEF if particular issues had arisen at the trust, for example over placement capacity.

The diversity of topics addressed emerged from participants’ accounts of this meeting: a trust senior educationalist said:

“We bring all the information from the practice areas to that meeting, look at feedback from students, from mentors, from audits, from any national surveys and we pull that together and look at any issues that fall out of it.” (TSE3)

And a learning community education adviser:

“We have a day where we discuss mentorship support, practice education. We look at good practice, we have working groups e.g. a mentorship development group that has developed for example a sign-off mentor guide, documentation re due regard, sign-off mentor simulation scenarios.” (HPL2).

An HEI senior educationalist:

“We ensure that NMC standards are being met, that we measure quality and we look at audits. Look at student experience, we design and develop practice education in assessment.” (HSE5).

And a mentorship module leader:

“It deals with issues relating to mentors such as what are our current needs, do we need more or less mentors, what should we have in our mentor updates. So we work with the trust to make sure we are delivering what they want.” (HMPL2)

Other topics discussed included: monitoring placement capacity and adjusting student numbers accordingly; cause for concern cases raised by students or by mentors, the new graduate programme; and protected time for mentors. The content and outcome of these meetings were fed back to a variety of professional meetings held in the healthcare providers.

4.5.2 Mentorship forum/meeting

A second HEI-based meeting that focused primarily on issues affecting mentors also had HEI and healthcare provider representation: all the PEFs attended and met with key HEI personnel including the senior educationalist with a practice focused remit (who chaired the meeting), the mentorship programme leader and teaching team, and also branch programme leaders and the placement officer. As with the strategy meeting (4.5.1), differing titles were offered but frequency was consistent; quarterly in one HEI and bi-monthly in the other. Topics for discussion included: content of the mentorship module; mentor updates; and student feedback on placements including that
from a recent national survey. Sub-groups of the members were appointed to take certain issues forward. HEI participants in this group saw one of its key purposes as enabling PEFs to express their views about the development of the mentorship programme. In turn, nearly all the PEFs spoke about the opportunity to feed in a trust perspective and in the words of one from each grouping:

“This is the place for me and the trust to provide feedback to the HEI about mentor preparation.” (TPEF1)

“We go there as group to represent from a practice perspective to the HEI the challenges we may experience as a trust for mentorship, the programme, NMC requirements, and then also to find out what’s happening in the HEI in the mentorship programme.” (TPEF5)

Outcomes of the meetings were fed back to higher level strategic meetings in the HEI; as one of mentorship programme leaders put it ‘thus closing the loop’.

4.5.3 Learning community practice meetings
Meetings were held at regular intervals for members of the learning communities of practice. The frequency of the meetings and the range of attendees varied from one learning community to another but the aim was a common one of sharing and learning from experiences as the following comments indicate:

“A monthly learning community meeting of the PEFs, the programme leaders and the link lecturers, it’s a good venue to go through everything.” (TPEF1)

“We have a quarterly meeting with all our link lecturers, which I lead to get a sense of how we are doing - what are key issues – anything we need to do to improve quality of contact with each other, the link lecturers’ contact with service etc.” (TPEF3)

“The link lecturer who runs it has meetings with the PEFs and mentor representatives to work through the allocation of students and pick up issues such as students going off sick, disciplinary issues, fitness to practice. All these issues are dealt with at that level.” (HSE3)

Other participants described how the outcomes of other meetings fed into the learning community meetings and vice versa:

“Anything from those two meetings (the practice working group and the mentorship forum) will be fed into the community of practice meetings and then into the mentors’ study days – so it all just gets fed through.” (TPEF6)

“They meet as a COP (community of practice) once a month or every two months, with PEFs etc, and they feed into the....[HEI strategy based meeting], which is the key strategic forum where I and my colleagues meet our practice partners.” (HSE5)

Meetings were also held with groups of mentors to enable feedback and information to flow between the various parties involved. Some of the PEFs described running days for all the key mentors in their learning community of practice, others of having update development sessions for mentors in certain clinical areas. Mentors working in the independent sector were perceived as perhaps being somewhat isolated from wider developments and a participant from each grouping
described initiatives to address this. One of the programme leaders ran a twice yearly forum for the independent sector and described its purpose thus:

“Every year I have two forums where I invite all the managers and their mentors from the independent sectors and they have a whole day here to be updated about the NMC regulations, requirements, good practice, sharing it out that kind of thing. So they have an opportunity to share among themselves as managers of independent sector placements. So that is another way in which we capture the opportunity to inform each other.” (HPD1)

The academic lead for a learning community of practice and who had link lecturing responsibilities for just under 20 practice settings in the independent sector held a termly meeting for the key mentors of each setting to discuss issues related to mentorship. Referring to a recent discussion of student assessment, this participant said:

“So we had that discussion and it was a brilliant meeting, it was just so interesting. And it was really well attended and I think they get a lot out of that because they can see that there’s somebody there from the university who’s interested in what they’re up to and listens to what they’re saying and I find it fascinating listening to what they do. I learn a lot from them as well.” (HPL6)

### 4.5.4 Meeting for specific groups and/or purposes

A range of meetings were held to address particular topics, some focused specifically on mentorship, others with implications for mentorship.

**Mentorship programme team:** Those involved in developing and teaching the mentorship module met on a regular basis at a meeting chaired by the mentorship programme leader and attended by the teaching team and senior educationalists who taught sessions on an occasional basis. Topics included reviewing evaluations of the course and developing the content of the module. In HEI-1, the course was taught by lecturers with a link to practice and more than one observed that the meetings provided an opportunity to feedback issues arising in practice relevant to the module, such as mentors’ competence in assessing students. Trust educationalists and PEFs were invited to attend; one of them observing that:

“We don’t always have the time to go. But I would definitely go if there was something I felt I needed to be there for.” (TSE3)

**Programme meetings:** Various meetings were identified that addressed aspects of the course offered by the HEIs, many of which had a direct bearing on mentorship. Some of the branch leaders held regular meetings with the link lecturers and the PEFs who supported students on the programme. Boards/teams responsible for pre-registration curriculum development and monitoring were mentioned; these were attended by HEI programme and module leaders and also had representatives from all the trusts. The trust decided who should attend, some sent the person responsible for the education contract, others asked the PEF to attend. Most comments about trust involvement in programme matters were positive but the occasional concern emerged; for example by one PEF over the current extent of their involvement given the practicalities of providing placements for the course:
“....but I just have concerns that maybe that bit is dropping off a bit and maybe we need to be more involved.” (TPEF1)

**Placement management team:** At HEI-1, both the programme leaders and some of the link lecturers described regular meetings with the dedicated placement team to review: which areas were being used; being creative with allocations and not overloading certain areas; and ‘keeping an eye’ on matching student numbers and mentor capacity in placements.

**PEFs forum:** Both groupings had a PEFs forum at which all the PEFs in healthcare providers (NHS, primary care and the independent sector) linked with an HEI met to discuss matters of common interest and concern.

**Strategic liaison:** The senior educationalists in the HEIs and the associated trusts referred to various strategic meetings held between HEI and healthcare provider personnel. From the perspective of an HEI senior educationalist:

“I also meet with the deans, the chief nurses, and the education leads on a termly basis to report what is happening in practice education and also to take feedback from the trusts, where they would like to see practice education going in the future.” (HSE5)

And by a trust counterpart:

“On a bi-monthly basis we have an education leads meeting with the HEI which is an opportunity to discuss any pre reg or post reg issues.” (TSE6)

**Other meetings:** In the course of the interviews, many participants referred to other meetings that they attended both within and beyond their own organisations and which covered a diversity of topics relevant to mentorship. Examples included: a staff student liaison committee; a forum developing strategies to support students with disabilities; and a pan-London group developing a new tool for student assessment.

**4.5.5 Key points on resourcing mentorship through discussions, planning and decision-making**

- The delivery of mentorship was underpinned by a diverse range of meetings between different groups within and across the HEIs and the healthcare providers with which they linked.

- The meetings provided a forum for planning and decision-making to ensure that mentorship capacity was sufficient and enabled people whose paths would not necessarily cross in the course of a working day to share information upon which these plans and decisions were based.

- The meetings drew together the multi-stranded nature of the activities entailed in providing mentorship for student nurses and the multiple working relationships on which these activities depended.

- The diversity and frequency of the various meetings demonstrate the resource intensive nature of the enterprise.
4.6 Resourcing mentorship: websites and materials
This second section on resourcing mentorship focuses on the development of websites and materials.

4.6.1 Personnel involved in developing resources
Participants discussed the way in which websites and materials were developed, their own role in the process, and perceptions of usefulness by HEI and trust staff and by the NMC in the course of validation visits. Findings indicated that the centre leading the development of resources differed between the two HEIs. In HEI-1, a Practice Education Support Unit (PESU) had been set up by a senior member of staff with a practice-focused brief and was the base for the three learning community education advisors in this HEI. Working with an outside company, the team had developed an electronic portal which housed a range of administrative databases, such as the mentor register, and a diversity of documents, some developed by the PESU team in conjunction with trust colleagues, others produced by national organisations. HEI-2 also hosted a practice website containing administrative databases and supportive material. Many of the materials had been developed by a group comprising the mentorship programme leader for HEI-2 who was based in an educational development unit in the faculty and the PEFs from the trusts with which the HEI linked. In both groupings, the PEFs also referred to websites and materials that had been developed within their trust. Findings are presented separately for the two groups to reflect their different approaches.

4.6.2 Group A (HEI-1 and trusts 1-3): developing resources
For Group A, information was provided by most (10/11) HEI participants and half (3/6) of the trust participants (3PEFs). Much of the detail was provided by the learning community education advisors. The mentor register and a placement capacity document were maintained on the portal which was thus an essential tool in managing student allocations. Participants spoke about regularly updating the register whenever they did a mentor update or confirmed a mentor as having fulfilled the criteria to be a sign-off mentor. Whenever placements were audited, information about current capacity was added to the database. The portal was thus used by HEI and trust staff to check how many mentors and sign-off mentors were ‘live’ in an area and thus how many students could be supported:

“I am very aware of how many mentors there are in the practice area and that is because I do a mentor update every single week, and I’m in and out of that mentor register.” (HPL2)

Information was available on the portal about which students were coming to each placement and mentors added what they expected of students in their practice area. The portal could therefore be used by mentors to access the names of their students and the date of their arrival and by students to know where they had been allocated along with some information about the placement. Evaluations of placements were available on the portal in the form of audits and student evaluations, and mentors could access evaluations of practice experience made by their students. Moreover, HEI staff could use the portal to send messages to mentors in the areas with which they linked.
A diversity of materials was available on the portal and participants described their involvement in developing these. One of the LCEAs spoke of the importance of making information available to mentors ‘in language they will understand’ and to this end the PESU produced a regular newsletter and a series of guidance leaflets on topics such as due regard, supporting students with disabilities, and courses of action to be taken when concerned about student progress. In the words of an LCEA:

“I think we are very good, very good at that and they’ve all been developed jointly with practice, that’s the key thing, everything is done in collaboration with our trust partners.” (HPL3)

One of the team designed a workbook that mentors could complete to enable them to do their annual update on-line, while another described leading on the development of a handbook to improve the continuity and consistency of mentor updates across all the organisations with which the HEI was linked. The workbook was linked on the portal to all the NMC documents relevant to being updated. Two of the PEFs and one of the link lecturers referred to the value of these workbooks in enabling mentors in their practice areas to get updated given that a face to face update with every mentor was not feasible. One of the senior HEI educationalists observed that the NMC always commented on the mentor handbooks as an example of best practice. Other materials developed with trust PEFs included a portfolio for mentors to document ongoing mentoring activities in preparation for their triennial review and information for mentors preparing to become sign-off mentors.

The portal was widely used by HEI and healthcare provider staff; mentors were shown how to use it when they were on the HEI-based mentorship course. A key strength of the portal was that HEI staff with practice links did not have to carry hard copies of all the documents with them since the portal could be accessed from trust computers. Some of the HEI participants recommended changes to the portal from time to time and attended meetings with the company who designed and maintained it to ascertain which changes could be made by HEI staff and which had to be made by the company and the costs that might be entailed. When asked to give examples of good practice in support of mentors, several of the HEI participants referred to the practice education portal; in the words of one of them:

“I think we have excellent resources, really excellent resources. We have probably the best resources I have seen of any HEI and I do go round and have a look you know….So our resources are great. I think our website is fantastic, it’s very advanced and very..it’s 24/7 support if you like. Because it’s not reliant on someone being in the office.” (HPL2)

Two of the three PEFs described material that they had developed for use within their own trust and these included: best practice guidelines that included addressing poor student performance; a student information pack that included advice to students to raise concerns with ward managers before contacting the HEI; and a distance learning package for updating mentors on-line.

4.6.3 Group B (HEI-2 and trusts 4-7): developing resources

For Group B, information about websites and materials was provided by four of the 11 HEI participants (mainly by the mentorship programme leader and the practice education lead) and by 6 of the 9 trust participants (the five PEFs and one of the senior educationalists). The HEI practice website had a telephone hotline so that if students or mentors had a sudden problem and were
unable to contact their link lecturer they would be able to contact someone else to advise them. The website did not appear to host the range of administrative databases, such as the mentor register, that the HEI-1 electronic portal supported. Trust websites were used by the PEFs to provide information for mentors, often in the format of a newsletter, about matters such as annual updates and triennial reviews.

The main focus of participants’ involvement in developing materials was a series of portfolios developed through joint working by HEI staff with a practice education focus in their remit and PEFs in the linked trusts. The mentorship programme leader described the PEFs as ‘very dynamic and pro-active’. The PEFs met up with each other in various fora (Section 4.5) and had worked together with support from HEI colleagues to develop a portfolio for mentors to use after they had completed the course. Referring to the PEFs’ longstanding wish to develop this; one of them observed:

“...and I think now having the mentor portfolio that was a big thing that we pushed for. So I think we are being listened to and we are having some input.” (TPEF6)

The portfolios were described by an HEI participant as making expectations of student performance very clear, how competence should be demonstrated and graded, and how to support students who were not meeting the required standard. The portfolio had been well received by mentors and was the subject of positive comment by an NMC team in the course of a recent visit. The mentorship programme leader said the portfolio had shaped the development of their new competency portfolio and also looked similar to the pre-registration student portfolio that mentors use with their students and to a document developed with PEFs for mentors to record evidence of mentoring activities for their triennial review; the aim was one of achieving consistency across the various documents.

The PEFs had also developed guides for mentors which gave them ‘handy tips’ when working with first, second and third year students; mentors were able to access these on-line and participants reported that mentors found them very useful. The HEI team had then integrated some of the content of this guide into the development of another guide; this time one for experienced mentors who were supervising student and newly qualified mentors. The HEI team and the PEFs had also worked together to standardise the annual updates to achieve a common core content and thus consistency of coverage across the healthcare providers.

The joint development of this group of documents was cited by several participants in response to questions about examples of good practice in mentorship. In the words of the mentorship programme leader:

“So we hope it’s good practice, we’re working towards good practice, to actually streamline the process the whole way through.” (HMPL2)

And another HEI participant with a practice education remit:

“It has improved and standardised mentorship..it tries to standardise standards across different trusts or organisations.. it’s been a very positive experience, I think it’s been our biggest success, it has been highly appraised by staff—making life easier.” (HSE5).
4.6.4 Key points on developing resources: benefits and challenges

- In both HEIs and their associated trusts, a considerable amount of resource was expended in terms of funding and staff time in developing websites and materials to support the different stages of mentorship – from taking the course through to preparing for triennial reviews.

- The overall aim was to enhance the quality of mentorship through providing timely information for students and staff and in clarifying, standardising and streamlining the various documents. Joint working of HEI and trust colleagues was seen as essential to the process.

- The outcomes of these endeavours were reported as receiving positive endorsement from mentors and from the NMC and were cited as examples of best practice in the support and education of mentors.

- As subsequent chapters indicate, there were concerns about the long-term sustainability of some of the resources being deployed to this end, such as staff time and ongoing funding for some of the posts.

- Challenges might also be presented by some of the potential changes identified in Section 4.2 such as trust mergers and HEIs being successful or otherwise in maintaining contracts for pre-registration student nurse education. Hence a group of organisations that had worked together to standardise a set of documents might then be split up and linked with other organisations using a different set.

4.7 Resourcing mentorship: course funding, study leave and time

The third aspect of resourcing mentorship was the cost of providing mentorship courses in terms of fees (4.7.1) and study leave (4.7.2) along with a range of other mentorship associated activities likely to require resourcing with funds and/or time (4.7.3).

4.7.1 Mentorship course fees

HEI participants were asked if they knew the cost per student that their HEI charged for the mentorship course while trust participants were asked if they knew how much their organisation paid per student.

Group A (HEI-1 and trusts 1-3): participants’ knowledge of cost of mentorship course

Of the 11 participants at HEI-1, eight participants offered a figure, two said that they did not know the cost of the course while one thought that the HEI did not make a charge for the course because the ‘trusts are mentoring our students’. For most (n=6) of those who offered a figure, the one given lay between £500 and £600 with answers varying from stating a precise figure to saying ‘well I think it’s about ….’. Another thought that the figure lay between £500 and £700 while the final member of the group said without hesitation that it was £650.

Several participants with practice links offered observations about course funding. One commented that some course members paid for themselves if they needed the qualification for professional development at a time when their trust was not funding any more places; the cost of the course was higher when paid for on an individual basis than the unit cost for a block trust booking. Two
participants observed that a free place was offered every year to each nursing home, one of them adding that ‘it’s one of the perks that they get because we don’t pay them to have our students’. And finally, one commented that trusts saw funding courses as important to their own future:

“And I think they see that (funding) as an important part, because I think maybe the trust overall has a picture that this is the pool they need to recruit from in the future so therefore they want these students to be well supported in practice because this is where they’re going to select their future staff nurses.” (HPL3)

Turning to the trust participants themselves, of the three senior educationalists, one said that although she did not know the cost, she knew that the trust’s business manager did know. The other two both gave a figure that was the same or near to the £650 given by one of the HEI-1 participants. One of these senior educationalists said that last year the trust had commissioned 110 places making a total cost of £71,500 to the trust. The other senior educationalist had commissioned 50 places at HEI-1 and just under a further 20 places at two other HEIs both of whom charged more for the course than HEI-1; the total annual cost to the trust was just over £50,000. Two of the three PEFs were unsure about the cost of the course, while the third gave a figure that was higher than anyone else had cited at just over £800.

Group B (HEI-2 and trusts 4-7): participants’ knowledge of cost of mentorship course

At HEI-2, five of the participants said that they did not know how much the course cost. Of the others two said it was about £600, another that it was £660 and fourth gave a figure of £710 referring specifically to a mentorship module that was part of a bachelor’s degree in nursing. (Two people were not asked the question). As with HEI-1, it was reported that free places were offered to staff working in the independent sector in recognition of provision of student placements.

Of the four trust senior educationalists, two were fairly clear about the cost to the trust. One of the two thought that the module cost about £680 and had commissioned 60 places the previous year at a cost to the trust of about £40,800; this participant added that all these places were guaranteed to be filled and that if any other course commissions were not filled it lay within their remit to use these funds to commission more mentorship course places. The second participant thought that the module cost either £650 or £720 and as 76 staff had been given a place the previous year, the total cost to the trust was either £49,500 or £54,720. A third senior educationalist did not have the information to hand although said that it could easily be obtained, while the fourth cited a course figure which was considerably lower than anyone else had given for the HEI-2 mentorship course resulting in a much lower perceived cost to the trust. The four PEFs were either unsure of the cost or were not asked the question.

Likely cost to trusts of mentorship courses

We did not independently ascertain the cost of the mentorship course offered at the two HEIs included in the study; our interest lay in participants’ perceptions of the cost. The findings showed that there was considerable variation in the degree of certainty about this figure and among those who were certain, considerable differences in the amount specified for the same course. A figure of about £650 was the one around which there was most likely to be correspondence between HEI and trust participants and this, combined with information about the number of staff sent on the course,
provided a range from £49,500 to £71,500 per annum for trust expenditure on enabling their staff to be qualified as mentors.

### 4.7.2 Study leave for attending the mentorship course

When asked about study leave arrangements for staff attending the mentorship course, there was recognition among HEI and trust participants that the NMC minimum requirement was five days of protected time, with some participants in HEI-1 and linked trusts saying that their aim was for six days.

HEI-1 and HEI-2 participants who were involved in the course as programme leaders, teachers, or in post-registration commissioning made a number of observations about the study leave granted to course members. Most commonly, they referred to the amount of leave actually given as varying not only between trusts but also within trusts. Examples included a participant describing a recent course at which some 20 nurses from the same trust each had a slightly different leave allocation. A number of actions by trusts were identified by HEI participants in relation to leave: the on-line component of the course had been requested by trust managers so that staff would not be out of practice for so long; some trusts then granted leave for the three face to face days but staff were expected to do the two or three on-line days in their own time; and in trusts that had implemented the 12 hour working day, staff were expected to do at least some of the course in their days off.

While concerns were expressed about the impact on staff of not getting the full leave, there was also recognition of the difficulties that trusts were experiencing in releasing staff. In relation to the former, some participants felt that it was unfair to expect staff to do a full day’s work and then have to work on-line in the evening on assignments that were course requirements. Another reported that some course members seemed tired on the face to face study days as they had come into college after working a night shift and would be working another night shift after the study day. Some HEI participants thought that the question of full allocation of study leave should be taken up with trust staff, others referred to difficulties experienced by trusts in this respect; as one of them put it:

"We are increasingly being told by trusts that they can’t release staff and I understand that it’s a real issue. The backfill isn’t there and that’s always a problem. Education is very expensive for trusts, supporting the education of students is expensive and it’s been done on goodwill." (HSE3).

The variation in study leave and factors pertaining to releasing staff reported by the HEI participants was also reflected in the response of the trust participants. Four of the seven trust senior educationalists said that staff in their trust were given the full five days study leave for the course, with two adding that they sometimes had to take this up with managers who had been proposing to reduce the allocation and make it clear to them that the full five days was a requirement of the course. In the other trusts, however, allocation of study leave varied by area; one of them explained the trust rationale as one of providing full leave for staff in areas with a need for mentors and then a half or a quarter of the leave in other areas depending on the ward manager’s budget for continuing professional development. This trust had a policy of working long days and staff who did not get the full leave were expected to do the other days in their days off, a policy that had been criticised by some of the HEI participants as being unfair to staff.
As part of their remit for commissioning mentorship courses, and indeed post-registration courses generally, the trust senior educationalists acknowledged practice area managers’ difficulties in releasing staff. These difficulties included: managing their ‘backfill’ budget which covered study leave, annual leave and maternity leave; balancing the needs of the area for qualified mentors with needs for other aspects of continuing education, for example a specific clinical skill set; and with individual staff needs for professional development, for example when the mentorship qualification was required for promotion. It was this professional development aspect of the mentorship qualification that led some trust participants to conclude that it was not unreasonable to expect staff to do at least some of the course in their own time. Part of the role of a senior educationalist with a remit for commissioning courses was described as helping and guiding managers with these often very difficult decisions.

Views of the PEFs in each of the seven trusts provided a similar picture to those of the senior educationalist interviewed in the same trust. One PEF, reflecting on the reduction of study leave from 12 days when she took the course predecessor (the ENB 998) to the current five days, felt that staff found doing the course in five days a struggle and that when a manager herself she had tried to give staff a bit more time:

“And I used to say to staff ‘If it means me giving you a couple of extra days study leave I’m happy to do that if it means a difference between you pass or fail the course.” (TPEF7)

The importance of support to facilitate a successful outcome was echoed by another PEF who said that while the trust tried to be as supportive as possible to students who struggled with the course, they might have to pay for themselves and study in their own time if they had to retake it.

Findings on study leave suggested some differences by branch. All the HEI and trust participants involved in mental health student nurse education said that it was the policy for staff to have the full allocation of study leave for the mentorship course, whereas among participants from adult and child nursing, differences were reported over how much leave staff were allocated.

4.7.3 Resourcing other mentorship associated activities

A range of other activities associated with mentorship that are the subject of NMC standards also required resourcing; these included the preparation of sign-off mentors and the provision of annual updates and triennial reviews. The details of how these were provided are included in Chapters 7 and 8 respectively but some information about resourcing is included in this section.

HEI and trust participants were asked whether the HEI made a charge for involvement in sign-off mentor preparation; all said that no charge was made and various reasons were given as to why this was the case. In relation to some trusts, participants said that preparation had been devolved entirely to the trust staff and that the HEI had no involvement in the process. In other trusts, preparation was undertaken jointly by HEI staff with a practice link and the PEF but no charge was made for the HEI staff involvement. Two of the HEI staff involved in sign-off mentor preparation linked with the independent sector; one describing this work as part of the link lecturer’s role and the other holding the view that although it was outside the link lecturer’s role, it was an investment for the future education of students in the independent sector and so undertook it for this reason.
Participants’ responses suggested that there were changes over time about respective HEI and trust involvement in sign-off mentor preparation. These included: HEI involvement alone moving towards joint preparation; joint preparation moving towards sole involvement by trust staff; and, more recently, moves towards including aspects of sign-off mentor preparation in the mentorship course as trust staff were struggling to prepare enough staff to meet the demand for sign-off mentors.

There were similar trends in relation to the provision of annual updates with varying inputs by HEI and trust personnel and changes over time about respective responsibilities in response to competing demands on time. Many activities which were regarded as part and parcel of the mentorship responsibilities of particular personnel, such as teaching on the mentorship course, finding practice areas for student placements, supporting mentors and students in practice, and having to hunt for information and/or documentation required could be extremely time consuming especially when difficulties arose. The ways in which this built up into a picture of much un-costed time involved in the provision of mentorship emerges from the more detailed exploration of these issues in subsequent chapters.

4.7.4 Key points on course funding, study leave and time

- Findings highlight some of the problems in ascertaining the costs of mentorship in terms of funding, leave and time.

- While the cost of the mentorship course to each trust must presumably be a known figure, there was considerable lack of certainty and consistency on this point.

- The extent to which staff were facilitated in attending the course through provision of study leave appeared to vary within and between trusts; it required ‘juggling acts’ on the part of practice setting managers in terms of allocating continuing professional development budgets and covering the work of staff on study leave.

- Those taking the course might well be required to contribute some of their own time if full study leave was not forthcoming.

- A range of other activities also required the time of HEI and trust personnel but could not always be precisely determined.

4.8 Overview observations on roles, resources and organisations

Findings presented in this chapter reveal the complex nature of the roles, resources and organisations that underpin the provision of mentorship for student nurses and which encompass both HEIs and healthcare providers. A wide diversity of activities were described in ensuring that students were provided with appropriate practical experience in settings in which there were sufficient numbers of adequately prepared mentors who, in turn, were supported by HEI and trust colleagues. A diversity of post-holders with both discrete and overlapping responsibilities for mentorship were involved in ensuring the provision and the quality of these activities; roles that included having a strategic overview as well as day-to-day direct involvement. Throughout the descriptions of these activities, the importance of multi-stranded working relationships, channels for regular communication between all parties involved, and partnership working between personnel in the HEIs and healthcare providers was evident.
Ensuring the quality of mentorship provision ran through participants’ descriptions of their responsibilities and this entailed multiple mechanisms and safeguards to ensure adherence to NMC standards, combined with creativity and flexibility in working practices and in developing supportive documentation and websites, often cited as examples of good practice. The overall picture was one of many individuals devoting considerable effort and time to enabling mentorship to be delivered in practice. At the same time, this resource was being expended in the context of a changing environment and one in which some indication of tensions were beginning to emerge. Current and forthcoming changes in the links between HEIs and trusts offered both new opportunities but also the potential to disrupt long established and productive relationships. There was reference to competing demands on time leading to changes in whether the HEI or the trust took the lead over certain activities and concern about sustainability of funding for innovative posts focused on practice education.

The overall picture that emerged from this chapter is one of a joint enterprise in educating the next generation of nurses but there was some indication that difficulties may be emerging. The ways in which these varying perceptions emerged in relation to particular aspects of mentorship capacity is part of the remit of following chapters.
Chapter 5: Mentorship capacity: mentors and sign-off mentors

Enabling mentorship to take place entails providing placements in which pre-registration students gain their practical experience and providing mentors and sign-off mentors who guide and assess their learning. The two are inextricably linked: first, the availability and ratio of mentors to students is one of the key criteria for a practice area being considered as suitable for student placements; and second through the differing but linked responsibilities of higher education and service personnel for mentorship capacity. This chapter focuses on mentors and sign-off mentors while placement provision is the subject of Chapter 6.

The chapter is structured as follows. Sections 5.1 to 5.4 focus on mentors: desirable qualities (5.1); eligibility criteria; motivation and selection (5.2); perceptions as to where responsibilities lie for ensuring sufficient numbers to meet demand (5.3), and views as to whether all nurses should be mentors (5.4). The account then turns to sign-off mentors for final destination placements: participants’ perceptions of the rationale for their introduction (5.5); clarity of requirements for sign-off mentors (5.6); desirable qualities (5.7); processes of implementation (5.8); responsibilities for ensuring that numbers are sufficient in final destination placements (5.9), and views as to whether all mentors should be sign-off mentors (5.10). Some observations on the findings as a whole are drawn together in Section 5.11.

Components of the mentorship hinterland concerned with roles, responsibilities, resources and activities were set out in Chapter 4. This chapter shows the way in which these were deployed in relation to providing mentors and sign-off mentors. Consideration is given throughout to differences and similarities of perceptions, experiences and views between Group A (HEI-1 and trusts 1-3) and Group B (HEI-2 and trusts 4-7) and between and within the different groups of trust and HEI post-holders.

5.1 Mentors: desirable qualities

Participants were asked what qualities they thought mentors should possess: responses differed considerably in breadth and depth drawing on participants’ own experiences as mentors and on their observation of mentors in training and in practice. Several common themes emerged and were grouped as follows in order of frequency: a commitment to student education (16); a range of skills to facilitate learning (16); various personal characteristics and behaviours (16); knowledge of the course and learning styles (11); clinical competence (10); approach to the student (9), and the same qualities as those required to be a nurse (6).

**Commitment to student nurse education**

Commitment to student nurse education was described in phrases such as ‘being interested in learners’, ‘having a fundamental belief in student learning in practice’ and ‘wanting to share their knowledge with students’. Some described this quality as having a passion for student education; in the words of one of the trust senior educationalists:

“A really good mentor is the person who really wants to educate, who’s passionate about what they do. It’s that enthusiasm that teaches people and educates people. You remember the great teachers and the people who were enthusiastic.” (TSE4)
Some participants amplified their remarks to the effect that a mentor’s key quality was a commitment to the advancement of the profession demonstrated through their willingness to educate the next generation of nurses.

**Skills to facilitate learning**

Skills most frequently cited were being a good communicator (10) and being able to provide feedback about performance (9). Good communication skills included a willingness to listen to the student as well as explaining practice. There was recognition that giving feedback required confidence on the mentor’s part if this was to be appropriate to the individual student’s progress and was described variously as: ‘giving good feedback whether it was difficult or easy to hear’; ‘to link feedback to the expected outcomes and professional behaviours’; ‘to give feedback in a fair and honest way’; and to ‘clearly and sensitively draw attention to areas for further development’.

Other skills included: identifying every possible opportunity for learning; developing the students’ confidence; empowering students by allowing them to practice; providing the rationale for every aspect of their work, and being able to focus on student learning in busy environments.

“*They need to have the capacity to be able to focus on the student even if it’s in little bits of time. Which is tough when they’ve got other competing things – not being so overwhelmed with their own work that they can’t see the student.*” (HPD4)

**Personal characteristics and behaviours**

A third group of comments described various personal characteristics and actions as being qualities needed by mentors and included the following:

**Acting as a role model**: Working in a way that students should emulate was emphasised with reference made to: working to the evidence and keeping up to date; demonstrating how providing safe care for a patient applies to their code of practice and how this translates into professional standards; and always acting in a professional manner. One of the trust senior educationalists highlighted the importance of role modelling thus:

“*Role modelling is key – so need to have good clinical practice, be clear about policies and procedures – when people say the student is poor it may be that they are displaying the processes that they have seen staff doing.*” (TSE5)

**Awareness of own practice**: Several participants focused on the importance of mentors’ awareness of their own practice, demonstrated through reflection and an awareness of what they did not know as well as what they did. One of the HEI programme directors summed up her views in this respect:

“*The most important quality is to be comfortable with yourself – with what you know and what you could do and what you didn’t. And to be able to admit when you didn’t know and to feel able to refer to someone else who did.*” (HPD5)

**Confidence**: Confidence in one’s own professional identity was mentioned; some participants saw this in terms of feeling sufficiently empowered to make changes to practice, others to being the student’s advocate. A PEF put the latter thus:
“To be able to say to other staff ‘No they don’t need to be making beds, they can come and do the medicines with me.’” (TPEF6)

**Knowledge of programme and styles of learning**
Knowledge of the programme and/or of different learning styles was identified by 11 participants. Aspects of the programme included: knowledge of the curriculum; knowledge of the NMC standards and all the associated documentation, and a clear view of what the programme involves in terms of expectations of students at each stage and each placement. Mentors needed to know what students were taught in university since this may differ from the mentor’s own working practices; to have an understanding of the theory behind mentorship, and how different learning styles may suit particular individuals.

**Clinical competence**
Students needed to feel confident in their mentor’s credibility and this was reflected by participants (9) who spoke about the importance of mentors being clinically competent and experienced in their speciality, and displaying a willingness to maintain this credibility through keeping up to date and expanding their knowledge.

**Attitude towards students**
Participants who included mentors’ attitudes towards students (9) referred to being welcoming and approachable. There was some division of view about friendliness, with some considering this as a desirable quality and others urging caution in that friendship might conflict with the mentor’s role as the student’s assessor; a PEF said mentors need to be sure that they are assessors and not buddies while one of the HEI programme directors felt that some of the more junior staff:

“want to be the student’s friend, they remember what it was like being a student and don’t like to be critical.” (HPD3)

Other positive attitudes towards students included: being enthusiastic and interested, and having an understanding of students’ needs, such as wanting to be included as part of the team and to do as much hands on care as possible. Understanding that students may be very apprehensive underpinned one HEI senior educationalist’s view that compassion was an important quality for a mentor:

“Starting off with the basic quality of a nurse, I think they should be compassionate not only towards their patients and clients but towards learners and students, particularly those who have never been in healthcare before because many of the students are petrified and very frightened of what is going on and they are insecure and don’t have the confidence and assertiveness skills to assist them. Sometimes I think compassion is missing – they are bit cold and distant and some of the socialisation that goes on in the NHS is very negative.” (HSE5)

Two participants used negative experiences reported by students to highlight undesirable qualities:

“oh no not another student.” (TPEF4)
“And I get quite despondent sometimes when I listen to things that students say to me. Recently I’ve had a student in ITU, she said I got given to one nurse and they didn’t want to have me because they were too tired and I despair what does that say about the profession.” (HPL6)

The same qualities as a nurse
For some participants (6), the qualities required by mentors were the same as those required by nurses; a point exemplified in examples from a trust and an HEI participant:

“They need compassion, they need to build good relationships with their clients, they need to be role models, good educators. Just a good nurse really, just all the things they should be doing as part of their day to day job.” (TSE3)

“Same qualities as you need to be a good nurse – good communication, empathy, but also to have a fundamental interest in developing people’s potential.” (MPL1)

One of the programme directors took this point a step further:

“It’s often seen as an extra and I don’t think it should be – I think it should be integral to the role of a nurse to be a mentor.” (HPD6)

These comments reflect aspects of the debate about whether or not all nurses should be mentors; a point explored with all participants and reported in Section 5.4.

Key points on perceptions of desirable qualities for mentors
Qualities deemed desirable in mentors included both a concern with the standing of the profession through commitment to educating the next generation, high standards of clinical competence and lifelong learning, together with possession of a range of knowledge and skills to facilitate and assess student learning.

- Subsequent sections of the report pursue participants’ perceptions about developing knowledge and skills through courses (Chapter 7) and the ongoing support of this development by colleagues (Chapter 7, Section 7.4, Chapter 8, Section 8.3).

- Associations between groups of participants and qualities described showed that a slightly higher proportion of trust than higher education participants referred to approaches to students (6/15 vs. 4/21) and individual qualities and behaviours (9/15 vs. 7/21) whereas the reverse was the case in relation to having a commitment to student education (4/15 vs. 12/21).

5.2 Becoming a mentor: trust criteria and organisational and individual motivation
The route to nurses becoming mentors was explored through: trust criteria for eligibility (5.2.1); whether obtaining the qualification was an essential pre-requisite for promotion (5.2.2); and individual and organisational motivation for nurses becoming mentors (5.2.3).

5.2.1 Length of time after qualification before becoming a mentor
The NMC standards state that a nurse must have been in practice for a year before starting the mentorship course (Chapter 1, Section 1.4). HEI participants were asked about the situation in the
trusts/sector with which they linked and the trust participants about the trust in which they worked. While most participants confined their response to the length of time required, others also gave their view on its appropriateness or otherwise (32 responded).

**Group A (HEI-1 and trusts 1-3): perceptions on length of time**
The mentorship programme leader in HEI-1 said that some trusts had asked the HEI to give staff a place on the course once they had been qualified for six months and that the HEI had agreed to this when first establishing the mentorship module on the grounds that staff would have been qualified for a year by the time they had completed the module. She went on to explain that trust criteria for continuing professional development for newly qualified staff thus became six months preceptorship followed by taking the mentorship module during the next six months, after which time staff were allowed to take other courses. The NMC, however did not approve of this policy and raised it at a recent visit to the HEI; consequently the criterion was changed to one year after qualification before staff could start the course.

All but one of the other participants at HEI-1 confirmed that this was the criterion in the trusts with which they linked and was also the case in nursing care homes in the independent sector. The response of the other participant suggested that this policy might not have been universally adopted in that the HEI sometimes facilitated trusts by offering the module at nine months so that staff had been qualified for at least a year by its completion. One of the HEI participants said that the policy in the trust with which she linked was usually 18 months but in her view this was still too soon:

“They may be friendly and near to students’ experience themselves but don’t have the experience of supervision, don’t have the experience of having to performance manage somebody. I think that they have to have had the experience themselves of when things go wrong to know how to then manage it and problem solve it and fix it. After 18 months, I’m not totally convinced they have that.” (HPL3)

Turning to trust participants, the three senior educationalists all confirmed the policy of one year after qualification before starting the course. They held differing views, however about its appropriateness: one had mixed feelings about the NMC’s reversal of the previous six months policy since she felt that some nurses were ready to be mentors after six months; whereas another felt that one year was too soon:

“But I would prefer to see it longer to give time for more development and ‘being rooted’.” (TSE1)

Two of the three PEFs also confirmed that the criterion was a year after qualification whereas the third said that the only criterion would be discussion at an appraisal.

**Group B (HEI-2 and trusts 4-7): perceptions on length of time**
A similar situation pertained in Group B. Three participants reported that trusts were under pressure to have more mentors and were trying to get their staff onto the course sooner than the NMC policy of one year after qualification. One of these, the mentorship programme leader, was concerned that recently qualified staff were given insufficient time to settle into their new professional role before taking on mentoring.
Other participants at HEI -2 either did not know if trusts specified a length of time after qualification, said that they did not think so, or that it was probably between six months and a year. Their observations on the subject included: staff were anxious to ‘get the mentorship course out of the way as soon as possible’ so that they could get on with a top up degree and it was important for staff to consolidate their own training before taking on mentoring. One of the programme leaders highlighted the distinction between the facilitating learning and assessing competence aspects of the mentor’s role in her response. On the one hand, drawing on her own experience of enjoying teaching when recently qualified, she said:

“I think you relate very nicely to the person who’s just done it.” (HPD4);

on the other hand she felt that experience was needed before taking on the role of an assessor:

“Fairness and objectivity and so on are quite hard to grasp when you are teaching a student and trying to get to grips with a new staff nurse role themselves. I think in that way I’d have to say a little bit more experience.” (HPD4)

In two of the Group B trusts, the PEF(s) and the senior educationalist said that the policy was a year after qualification. Responses were not as consistent in the other two trusts with slightly differing views given by the PEF and the senior educationalist in each, and a range of times given from about six months, at least 9-12 months, one year and no specific time. One of those stating that trust policy was a year observed that up to a year was needed for newly qualified nurses to make the transition from student to staff nurse and it would be inappropriate to expect them to mentor sooner. Another regarded the mentorship course as a ‘gateway education activity’ in that it was a predictor of future progress and need:

“If they pass the mentorship module it gives us a better indication of the likelihood of them going on to other educational activity at a higher level – it’s a good flag for us as indicating if this person needs more support if they fail it.” (TSE7)

Key points on length of time

- Findings suggest that trusts are under pressure to ensure that they have sufficient mentors to meet demand and that there have been attempts to bypass the NMC standard of one year after qualification before staff can take the course.

- Views differed over the appropriateness of the standard with some participants feeling that a year was appropriate, some that staff needed longer than a year, and others that six months was sufficient for some nurses.

5.2.2 The mentorship qualification as a requirement for promotion

HEI participants were asked whether qualification as a mentor was a criterion for promotion in the trusts/sector with which they linked and the trust participants were asked the same question in relation to the trust in which they worked (34 responded). While most participants confined their response to a yes/no answer, others gave their views about the relevance or otherwise of mentorship to promotion.
Group A (HEI-1 and trusts 1-3): requiring the mentorship qualification for promotion

The majority of participants in this group said that having the mentorship qualification was either an essential criterion for promotion or, if not, was still strongly beneficial to applications. Turning first to the HEI participants, this view was expressed by the two senior educationalists, the two programme directors and three of the five lecturers who linked to practice settings. Of the other two lecturers, one who linked with a primary care trust was unsure and the one who linked with nursing care homes said that it was not a criterion in these settings.

There were some differing emphases in views among trust participants. The senior educationalist and the PEF in Trust 1 said that it was not a criterion for promotion although the former added that having the qualification and being able to state why it benefitted their career helped applications. In Trust 2, the senior educationalist said that it was needed for promotion to Band 6; the PEF reported that people had been promoted without having the mentorship qualification although personally thought it was necessary for a Band 6 to have credibility in discharging the responsibilities of the post. Both Trust 3 participants said that the qualification was a criterion for promotion although one was unsure how strictly it was always applied.

Group B (HEI-2 and trusts 4-7): requiring the mentorship qualification for promotion

There was some degree of uncertainty among the HEI-2 participants. Six (two of the senior educationalists and the four programme directors) did not know whether the mentorship qualification was required for promotion. Among the others, both link lecturers thought that it was required, while the mentorship programme leader and the programme teacher thought that this was less the case than had been previously. The third senior educationalist thought that while it might not be specified as essential:

“I think from a cultural perspective it is becoming ensconced into...oh yes, I’ve got to get my mentorship to get to the next band.” (HSE5)

A diversity of responses emerged from the trust participants. The Trust 6 senior educationalist and PEF said that the mentorship qualification was a criterion for promotion whereas the Trust 7 participants said that it was not. In Trust 4, the PEF thought that the mentorship qualification was not as important for promotion as previously and the senior educationalist said that it was not specified as essential but that all job descriptions ask for teaching and assessing qualifications. In Trust 5, the PEF said that there was an expectation that the qualification was needed to progress from Band 5 to 6 although knew of senior staff who did not have the qualification and the senior educationalist said:

“I don’t necessarily think so – its part and parcel of what we expect nurses to do.” (TSE5)

Key points on whether the mentorship qualification is required for promotion

- There was a greater degree of certainty among HEI-1 participants than among their HEI-2 counterparts about whether the mentorship qualification was required for promotion in the trusts with which they linked.
Based on the views of those who were certain (both HEI and trust participants), holding the mentorship qualification appeared more likely to be a criterion for promotion in the Group A than the Group B trusts.

5.2.3 Staff motivation for wanting to take the mentorship course

The importance or otherwise of the mentorship qualification to promotion prospects was further illuminated by participants’ perceptions of what motivated people to take the course. The main sources of motivation for taking the course were:

- career progression in that it was required for promotion and as a prerequisite before being allowed to take other courses
- enjoyment of teaching students
- contributing to the wellbeing of the profession through developing others
- personal benefits of mentorship (other than promotion)
- being sent by a ward/service manager in order to meet organisational needs for mentors

Trust participants: views on motivation for taking the mentorship course

Among trust participants there was a focus on enjoying teaching and a commitment to develop others as sources of motivation for becoming a mentor. Six of the seven senior educationalists referred to these sources:

“They see the opportunity to do the course as positive, they can see it as progression... We have a pool of staff who want to be mentors because they want to have an input into the next generation of nurses coming through.” (TSE7)

One of the group spoke positively on the basis of a recent review of application forms and said that they had been heartening to read with a focus on wanting to teach students, enjoying teaching and wanting to give something back to the profession. Another referred to encouraging retention since if students enjoyed a placement they were more likely to want to work in the area after qualification. Some added that promotion was also a consideration:

“I think it’s an interest in education, it’s an interest in supporting others. I think that’s the main thing – the support. And sometimes it will be dare I say it’s the fact ‘Well I won’t get promotion without it’.” (TSE 2)

Just one of the senior educationalists who had said that promotion in the trusts was dependent on having the mentorship qualification saw this as the main source of motivation:

“It’s the carrot to promotion – you need it to get from band 5 to 6. It’s a natural career progression, it’s the first big course you do after qualification.” (TSE6)

These views were echoed by the PEFs in the following observations: staff saw it as the next step in developing their portfolio; the pride of becoming a mentor; supporting the learning of others and
helping them grow; enabling career progression through being allowed to take other courses after mentorship, and promotion.

**HEI participants: views on motivation for taking the mentorship course**

Perceptions of HEI participants were based on experience of teaching on the course and of knowledge of staff through spending time in practice settings.

Those who taught on the course were the most likely to place an emphasis on promotion and being sent by managers; it should be noted that although the learner mentors would include staff from the trusts in the study, staff from other trusts linking with the HEIs would likely be present as well. The HEI-1 mentorship programme leader said that most were taking the course in order to get promoted, some had been sent in order to meet their KSF targets with about 25% there because they enjoy teaching students. Her counterpart in HEI-2 thought that although the extent to which the course was needed for promotion had lessened over time, more recently it was becoming important again as staff perceived it as beneficial in a climate of increasing competition for jobs. The mentorship teacher also referred to the course being required for promotion and added that it was sometimes required as a condition of a recent promotion; in her view this was the worst time to become a mentor since the staff member was also learning about the responsibilities of a higher level job. All three spoke of staff being sent on the course by their manager to increase mentorship capacity in their practice area and that it was ‘their turn to go’.

At HEI-1, others with experience of teaching on the course echoed these views and included senior educationalists with recent experience of teaching on the course and link lecturers with current experience. One of the latter said:

> “If I teach a class of 25, 24, on the first day when I ask them ‘why are you here’ they tell me its because they’re band 5 and their manager has said you have to get your mentorship. Their trust won’t let them do another course unless they get their mentorship, or they’ve been around a long time and their manager is sick of them not doing it...And all of those reasons for coming onto the mentorship course are just wrong”.... “And you can see them sitting there and you can see ‘just tell me what the assignment is and I’ll pass and then I can go on the course I want to do or I can apply for my Band 6 or I can get my manager off my back’.” (HPL2).

and went on to say:

> “One person might actually have the passion that I do for nurse education and mentorship and if you’re lucky two.” (HPL2)

Other HEI participants drawing on conversations with practitioners, including mentors, perceived a greater diversity in sources of motivation. Commitment to the education of the profession was reflected in comments such as recognising that nursing is about teaching the next generation of nurses as well as patient care and therefore wanting to be prepared to take on that role. Being a mentor was seen as facilitating self-development through demonstrating knowledge to students. There was also the effect of the historic view that mentorship should be the first pre-registration course after qualification. Promotion was mentioned although as the previous section showed, there were diverse views as to whether it was as important as previously. Some with more of an
overview brief spoke about organisational motivation in that trusts needed to have large numbers of mentors to cope with the rapid movement of students through placement areas and the perception by managers that the reputation of clinical areas depends on having students. Hence some staff take the course because they have been told to do so.

A different picture emerged for the independent sector from the link lecturer who linked with a large number of nursing care homes. Here, the course was not a criterion for promotion and motivation focused on prestige. From the home’s perspective it was the prestige that came from linking with the university while for the individual nurse it was a mixture of prestige from the university link, enabling them to keep up to date in situations in which practice did not change as rapidly as in acute hospital settings and also, for many whose first language was not English, a means of improving their communication skills.

Two HEI senior educationalists thought that motivation for taking the course was reflected in the quality of mentorship subsequently offered to students; in the words of one of them:

“...some because they like to teach and support students and you can see this reflected in that students enjoy being mentored by them. You can see a really good mentor because they give extensive feedback for the student. Some do it as process to get somewhere – you see the standard (of mentorship) is satisfactory and that’s about it.” (HSE5)

Key points on views on motivation for taking the mentorship course

- Participants identified diverse sources of motivation for becoming a mentor.
- The trust participants in the main focused on the enjoyment of teaching and the personal and professional benefits as the sources of motivation for taking the course albeit that several had said that the course was a criterion for promotion in their trust.
- HEI participants who taught on the course were more likely to include gaining promotion and being sent by a manager, while perceptions based on knowledge of staff working in placement areas reflected a more diverse range of sources of motivation.

5.3 Maintaining sufficient numbers of mentors: processes and responsibilities

The account now turns from motivation to gain the mentorship qualification to organisational processes of ensuring that there are sufficient mentors in each area to meet demand. These processes include: making assessments of how many mentors are required (5.3.1); commissioning the requisite number of places on the HEI based mentorship courses (5.3.2); deciding which staff will take up the places (5.3.3); maintaining the mentor register (5.3.4); and responsibilities for ensuring that mentor numbers are sufficient (5.3.5).

5.3.1 Assessing the number needed

Assessing the number of mentors in each practice area and hence the additional numbers needed was required to inform the commissioning of places on the HEI-based mentorship course. Trust senior educationalists said that it was their responsibility to assess and maintain mentorship capacity and to commission places on the course accordingly. The assessment drew on three sources of
information: the mentor register; educational audits of placements; and detailed knowledge of practice settings.

i) The mentor register:
Some of the senior educationalists in trusts and HEIs observed that the register of mentors in each practice area and the date of their last annual update is a key source of information about mentorship capacity:

“The register makes it very clear to us where there are gaps and thus informs the commissioning.” (TSE4)

“The mentor data base helps us to identify areas where staff need to update.” (TSE5)

“We rely on the mentor register for each placement to make sure there are enough there.” (HPD1)

ii) Educational audits:
Several participants referred to the regular placement audits as a source of information. For example, an HEI A participant with a practice link said:

“We look at the number of mentors we’ve got and how many staff are going to be on the course and are on the course at the time.” (HPL3)

And the PEF she liaised with expanded on this thus:

“We plan it out at the educational audit – reviewing the number of staff who are mentors and have an action plan about getting those who are not mentors onto the course and who’s going in what order and when. So it’s all time frames, so that again there are clear lines of responsibility and that’s reviewed at the 6 month review of the educational audit.” (TPEF3).

iii) Local knowledge:
The knowledge that came from day to day working in practice areas was also identified as an important source of information. This featured in the role of PEFs, for example:

“I’m the one who knows how many students are coming because I meet with the university, so I have to be gauging how many mentors we’ve got. I don’t have a role in saying how many people should go on the mentorship programme but I talk about it in the mentor updates to get mentors to encourage (other) staff to go on the course.” (TPEF4)

Another PEF said that while responsibility for ensuring that there were enough mentors lay with her line manager, the latter’s actions in this respect were based on her (the PEF) knowledge of practice areas such as ward managers telling her that they could not take students as they no longer had any mentors. The line manager then arranged for staff from this area to attend the mentorship course. Trust senior educationalists acknowledged the importance of the PEFs role in this respect:

“PEFs have a good working relationship with the clinical areas and know if there are changes through services changing, new staff or staff leaving.” (TSE7)
Local knowledge also featured in the role of the HEI-1 learning community education advisors (LCEA), described by one as:

“Keeping my ear to the ground and so knowing then for example if an area has people going on maternity leave.” (HPL2)

A second LCEA talked about the importance of planning ahead; in the trust she linked with many of the more experienced mentors were nearing retirement and so there was a big push to get community staff nurses onto the course:

“We’ve got to start to build up and it takes pressure off those who are mentoring at the moment. It’s about looking, I think, not thinking that’s how many mentors we’ve got, we’re alright. It’s keeping an eye on everything, evaluating who we’ve got where.” (HPL1)

5.3.2 Commissioning places on the course and liaising with the HEI

Information about the number of mentors in practice and the number needed was then fed into the commissioning process; this varied in detail from one trust to another but essentially involved each area making an education business plan having decided on the number of places needed on the mentorship course to maintain mentorship capacity. The commission was then placed with the post-registration personnel at the HEI and the mentorship programme leaders made sure that they had the lecturing staff available to deliver the course to the numbers attending.

Experience of the HEI-1 participant with a post-registration brief was that commissioned places were relatively static over time, totalling about 800 overall per annum. A recent small increase had been occasioned by a mental health trust changing from its existing HEI provider to HEI-1. A certain number of places were set aside for the independent sector which was offered free places to ensure that they had sufficient mentors to support students. Any places available after the trust and independent sector requirements had been met were offered to the small number of people who self-funded the course having been unable to secure trust funding.

Two of the HEI-1 participants with trust links said that their trusts were keen to put staff forward for the course:

“The trusts are all very keen to ensure that they have enough mentors and to get people on the course. They are good at putting people forward and encouraging them to do it.” (HPD2)

While a third felt that the trust should be more proactive in this respect:

“I would like to see more mentors and more of the placement providers supporting their nurses to become mentors. I would like to see greater collaboration and greater priority being put on that by the placement providers.” (HPD1)

Experience of the HEI-2 participants was that trust numbers varied from year to year and that there had been an increase in requests for places from nursing care homes. Leaders of the various modules offered spoke of the need for flexibility:

“We have the ability to expand and contract in order to meet what’s needed on the ground.” (MPL2)
Trust senior educationalists referred to this variation:

“You might find that one year you commission more places because a lot of staff who leave are mentors and then you need more whereas the next year you don’t need so many as the workforce numbers are stable.” (TSE4)

Trust participants also spoke about the importance of their relationship with the HEI personnel in managing this variation and the difficulties that could ensue when there was a change of HEI personnel and temporary lack of continuity and knowledge of the trust. Regular meetings between chief nurses and the HEI deans provided a forum for discussing issues relating to the mentorship course; one example included deans drawing attention to commissioned places that had not been taken up and it was reported that the chief nurses would then refer back to practice managers to remind them that if places were not used then the trust had wasted the funding.

5.3.3 Deciding who should attend the course
Trust and HEI participants said that decisions about which members of staff were selected to take up the commissioned places was made by the manager in each practice area. The eight PEFs said that decisions were based on the outcome of staff appraisals.

The HEI’s role in the process, as described by the mentorship programme leaders, was to check that staff met the NMC entry requirement of 12 months post-registration experience and were in active practice. Some participants from both HEIs expressed reservations about the selection process and these were two-fold. First, there were concerns over whether all those selected had had sufficient time to consolidate their skills and were ready to take on the responsibilities of mentorship:

“Managers have to be sure that it’s the right time for a particular person to go on the course. It may be better for them to consolidate skills further before they go. It’s important that mentors are functioning properly as this has implications for the future workforce. I do wonder if everybody takes it sufficiently seriously.” (TSE4)

The second reservation focused on whether trusts needed to be more selective about who was sent on the programme rather than sending everyone as at present; a point that is linked to debates about whether all staff should be mentors (Section 5.4).

5.3.4 Responsibilities for maintaining the mentor register
Once a staff member had successfully completed the course, their name was added to the mentor register for their practice area and a note made of when they were due for their annual update. As noted above, the register is an important source of information when assessing the numbers of mentors available in an area. Keeping the mentor register up to date was thus a requirement of the NMC (Chapter 1, Section 1.4) and a check in this respect features in NMC validation visits. Hence participants were asked where responsibility lay for maintaining the register.

Group A (HEI-1 and trusts 1-3): maintaining the mentor register
Group A participants were clear that trusts were responsible for maintaining the register. This view was held by the senior educationalists with PEFs describing their work in this respect at a day to day level.
HEI-1 participants with a practice link concurred with the view that keeping the register up to date was a trust responsibility but had differing perspectives of how this worked. Thus, for one it was clear cut:

“I need the placement areas to take responsibility for keeping it up to date.” (HPL3)

For a second, it was very much a shared activity with the PEF at a day to day level:

“We meet with the CPF out in practice to really look at where we are at with mentor updates, with the staff who can and can’t mentor and who is saying they can’t mentor. And looking at the register because there are discrepancies there.” (HPL5)

While a third did the work herself:

“It’s not my responsibility but I do it. I’m very aware of how many mentors are in each practice area, I do a mentor update every week. And so I’m in and out of the register. I go through the register and see where they are short and these areas gets priority places in the course….I send emails to administrator to say which areas need more mentors.” (HPL2)

HEI-1 participants with a trust overview brief also stated that the register was a trust responsibility but referred to an HEI input in ensuring these were kept up to date. One of the programme directors said that a senior member of staff with a practice based remit had access to trust registers and regularly checked through them. Another senior educationalist said that some trusts were better than others at keeping their registers up to date but felt that some were not wholly accountable in this respect. This created problems for the HEI who had to chase such trusts since the HEI would be penalised by the NMC if registers were out of date at the time of their validation visits:

“But then in a way the HEI becomes responsible for the register as in we’re chasing the trust to say your register isn’t up to date and all this but it’s not the trust that gets the penalty it’s the HEI because at the end of the day it’s not the trust that’s getting slack for not meeting the standards, it’s the HEI.” (HSE2)

Group B (HEI-2 and trusts 4-7): maintaining the mentor register

In Group B, the trust senior educationalists and PEFs said that they were responsible for keeping the register up to date including the record of annual updates. As one of them said:

“It’s not just about having mentors, it’s about having up to date mentors.” (TPEF6)

One of the PEFs however, held the view that it was supposed to be a shared responsibility but in reality:

“It’s the PEFs that do all the work. We advise managers if their staff haven’t been for an update.”(TPEF7)

In contrast to the HEI-1 participants, those in HEI-2 had diverse views about where responsibility lay. One of the practice links thought that it was the PEFs’ responsibility, while another thought it was the HEI:
“I suppose responsibility for making sure that the mentor register is up to date lies with me but I very much rely on the PEFs who are superb. As far as the trust is concerned, it would be my responsibility and the HEI practice lead.” (HPL7)

The programme directors and one of the senior educationalists regarded it as a trust responsibility while another of the senior educationalists said that responsibility was shared between the HEI and the trust: thus

“We keep a database and we monitor it and notify our PEFs if they’re falling behind and that gets reviewed at the practice working group and on the whole they handle it very well. The PEFs do respond when we contact them if we have got a concern about it.” (HSE3)

5.3.5 Responsibilities for ensuring that mentor numbers are sufficient

When asked about responsibilities for ensuring that there are enough mentors, most participants referred to aspects of their own role such as maintaining the mentor register and commissioning places on the course and/or attributed it to a specific person. With regard to the latter, then among trust participants, it was seen as the PEFs’ responsibility at a day to day level with ultimate responsibility lying with one of the senior educationalists, most often the PEF’s line manager. Among HEI participants, views differed with responsibility being attributed to the branch leaders, to those with a practice link, or to the PEFs.

Some of the trust and HEI participants responded by describing the joint nature of responsibility and this was eloquently summarised by one of the HEI senior educationalists:

“It’s a joint responsibility in the sense that the trusts have to confirm their capacity for students and that’s based on their ability to have sufficient mentors because capacity is as much about mentors as physical placements. Equally we [the HEI] have a responsibility to ensure that’s there by providing the courses to develop new mentors and that the mentors already there meet the NMC requirements so that they can be used. I see it as joint responsibility through the signing of the placement agreement.” (HSE1).

5.3.6 Key points on maintaining sufficient numbers of mentors

- Ensuring there are enough mentors is a multifaceted matter entailing several processes, diverse sources of information and a range of personnel with separate and interlinked responsibilities.

- The point at which a trained mentor is in position in a practice setting is proceeded by assessment of the mentorship needs of the area, allocation of CPD budgets and commissioning places on the mentorship course; appraisals with staff, decisions about whom to send on each course, the course itself, and entry of the mentor’s name into the register upon course completion.

- Sources of information that underpin these processes depend on staff keeping records up to date and on sufficient presence in practice areas to be aware of practitioners’ intentions that may affect capacity.
Most participants were involved in one or more of these processes, with varying degrees of intensity.

Trust senior educationalists were regarded in the main as having overall responsibility for maintaining sufficient numbers but PEFs in particular were key to this happening in practice through assessing capacity, developing close working relationships with practitioners, and maintaining registers.

HEI personnel also played an essential part: those with practice links were key to knowledge of practice circumstances and implications for mentorship capacity, and the course itself was provided by HEI personnel who might have to respond quickly to changing demands for places.

Working relationships across trusts and HEIs were pivotal and included PEFs and link lecturers working together to assess and maintain mentor numbers; trust and HEI staff negotiating over commissioned places and ensuring that these were taken up.

In the main, there was agreement as to where responsibility lay for the various processes and information gathering described.

Nearly all the trust participants regarded the mentor register as a trust responsibility as did the HEI-1 participants. The HEI-2 participants had more mixed perceptions of where responsibilities lay. There was some indication from HEI-1 participants that some trusts had to be chased up over this issue.

5.4 Mentorship: a generic or specialist role?
There has been much debate as to whether all nurses should become mentors and similarly whether all mentors should become sign-off mentors; questions that are integral to the goal of ensuring that mentorship capacity is sufficient. All participants were therefore asked for their view on whether all nurses should be mentors (this section) and secondly whether all mentors should also be sign-off mentors (reported in Section 5.10).

Participants’ responses to the first question fell into four main groups: all nurses should be mentors; only some nurses should be mentors; they were uncertain and could see advantages and disadvantages of both courses of action; or that the question should be approached differently and there should be a different model of mentorship to that at present. As the groups of participants differed in the nature of their relationship with mentorship in practice, responses are presented by group to ascertain whether any differences emerged.

5.4.1 Trust participants, senior educationalists: views on generic/specialist debate
All the trust senior educationalists held the view that all nurses should be mentors. Four themes emerged from the reasons advocated for this view: two were positive aspects - mentorship is an integral part of the nurse’s role (5) and learning the skills of mentorship benefits individual nurses (2) while two focused on the negative aspects of mentorship being a specialist role - non-specialists would abdicate responsibility for students’ learning (3) and the generic route was the only way of
managing the mentoring workload (2). Just one of the trust senior educationalists, although in favour of all nurses being mentors, also highlighted drawbacks to this position.

**Reasons for favouring the generic role**

Mentorship is an integral part of the nurse’s role: Observations made about mentorship being an integral part of the nurses’ role were twofold in nature: first that it is part of a nurses’ responsibility to train others; as one said:

“It should be a requirement, part of your duties as a nurse that you are willing to support and help student nurses with their training.” (TSE3)

Second, the behaviours required to teach a student nurse were the same as those for explaining care to a patient; one of those holding this view explained using pressure ulcer care as an example:

“It’s critical thinking….if you said to me ‘why are you dressing that pressure ulcer the way you are’ I should be able to explain for many different reasons. It’s about the grade, it’s about preventing deterioration, it’s about true comfort, it’s about lots of things, but I should be able to explain that. If I can explain that to a student nurse I can explain that to a patient and I can document accordingly, and I will be able to justify to my team why we’re providing the care we do. It will be reflected in the care plan.” (TSE4)

**Learning mentorship skills benefits nurses:** Nurses were said to benefit from becoming mentors since working with students empowered them to develop and increase their own knowledge base; one participant added that mentorship was a two way process and that nurses learnt from being challenged by students about what they are doing and from students’ more up-to-date knowledge.

**Abdicating responsibility if mentoring is a specialist role:** Concerns were expressed that if mentoring becomes a specialist role, then other members of staff may not regard supporting student learning as part of their role; thus:

“Well that’s not my remit, so I won’t worry about that, I won’t have anything to do with that.” (TSE5)

**Managing the mentoring workload:** Concerns were expressed that if mentoring students was confined to a few specialists, then mentorship capacity would be insufficient. One of those holding this view spoke at some length about the importance of developing mentorship skills in all nurses, even if they felt reluctant in the first instance:

“I think it should be the role of each nurse. I really believe that all nurses should take part and that’s the ideal world. Not every nurse wants to take part, not everybody is a good communicator maybe. But I think it’s a skill that we need to develop because you have new staff coming into an environment and if we leave that only to one person who teaches the students then that workload becomes unmanageable. So I do believe that each nurse should develop those skills. I think sometimes it can be hidden and we don’t always develop it within the person or we don’t have it naturally, it’s a flaw, but it’s helping to develop that.” (TSE2)
**Disadvantages of the generic position**

One trust senior educationalist while favouring the generic position also referred to a disadvantage; namely that the link to promotion led to some nurses regarding mentorship as a tick box exercise – something that they had to do in order to get promoted. Moreover the pressure to become a mentor might coincide with a time when they were not best placed to take it on because of personal circumstances.

### 5.4.2 Trust participants, PEFs: views on the generic/specialist debate

The view emerging from the PEFs was very different from that of their senior educationalist colleagues, in that just two of the eight were in favour of all nurses becoming mentors. One of the others advocated a different model for student nurse learning and the largest group (5) thought that only some nurses should be mentors. One of these five said that they had been thinking about this issue for a long time and had gradually come to the view that mentors should be handpicked and that linking it to career progression might not necessarily be the best strategy.

**Reasons for favouring the generic role**

Reasons given by the two favouring the generic position echoed those of the senior educationalists; firstly that it is part of the nursing code to share knowledge and skills with students and secondly, that the specialist route will not provide sufficient capacity.

**Reasons for favouring the specialist role**

Three themes emerged from the reasons offered for mentorship being a specialist role: one focused on the negative effects of the generalist position (4); and two on taking forward positive aspects of the specialist position - developing a specialist career path for those who did want to be mentors (2) and recognising the contribution of those who did not want to do so (3).

**Lack of suitability to be a mentor:** The generalist position was rejected on the grounds that not all nurses were suitable to be mentors, characterised in terms of ‘not being fit to be mentors, not being good at mentoring; and not liking students’. One added that lack of suitability of some mentors meant very mixed quality of the mentoring provided for students.

**Develop mentorship as a specialist career:** A specialist career pathway was advocated for those who wanted to be mentors with perhaps a pathway developed beyond the initial mentorship qualification. This choice should be recognised in professional development profiles and would have the benefit of retaining experienced practitioners among the pool of mentors:

> “Because as people get more promotion, so your most sort of experienced qualified nurses tend to get more distanced from students and it does feel it should be more the other way round.”
> (TPEF7)

And improve the quality of mentoring:

> “Because I think what we have now is a situation where everybody has to do it – not everybody is equipped to do it, not everybody wants to do it, so you get a mishmash of quality. Whereas if those people who have a gift for doing it, are really interested in doing it, have been appropriately
trained and given that as part of their role, so they’re given time to do it properly, I think that
would make for better mentoring, to be honest.” (TPEF 8)

Recognise different contributions: Recognising contributions to the profession of those who did not
want to mentor was identified by four of the PEFs as an important corollary to the specialist
position. Contributions were described in terms of being good practitioners and supporting students
without being mentors. One participant expressed it thus:

“We have got people working in this organisation who have been working as a nurse for many
years and have chosen not to go down that route, but are very good clinicians with service users,
keep themselves up to date, but actually choose not to be mentors. They’ll support the students
but don’t want the added responsibility as it were” (TPEF 3)

Approaching mentorship differently
Finally one of the PEFs advocated a return to the HEI based clinical assessors model of student nurse
education, primarily on the grounds that practice staff did not have the time to take on mentoring in
addition to all the other demands on their time.

5.4.3 HEI participants, lecturers with a link to practice: views on generic/specialist debate
So how did the views of the HEI participants compare with those of the trust counterparts on this
question? Starting first with the lecturers with a link to practice as those most likely to see
mentorship in action (7), views of this group were divided in that two favoured t
the generic position, two the specialist position while three saw both sides of the question (responses of these three are
considered with the other two groups as appropriate).

Reasons for favouring the generic role
The two who thought that all nurses should be mentors saw mentorship as part of the nursing
journey. For one this was from qualified nurse through to sign-off mentor while the other saw this
as starting during training, attributing her views to her own experience:

“I think right from qualifying I always assumed that I would mentor, that it was just a part of the
role, because I did it when I was a student – I remember being supported by 3rd year students and
then when I was a 3rd year I remember doing it and I think that it was an integral part of the
learning process…. And after the shift the staff nurses in some areas would then take you aside
and then actually do a teaching session with you which was fantastic. And I supposed that was
ingrained in me by the time I qualified and I just assumed that I would always mentor.” (HPL5)

Of these two participants, one had a particular responsibility for nursing care homes and thought
that homes should assess at interview whether applicants would be able to become mentors and
then inform them that they would be sent on a mentorship course in a year’s time. The other felt
that the generic position was the only way of coping with the mentoring workload and that working
with questioning students had the benefit of helping nurses maintain competency. Reasons given by
those who saw both sides included: a professional responsibility to produce the kind of newly
qualified nurse we would like to be working with; specialist roles would lead to students losing the
benefits of being supported by a team with different teaching styles and different perspectives on
practice; and that other nurses would be de-skilled in terms of teaching.
Reasons for favouring the specialist role

The main thrust of the views of those with concerns about the generic role was that mentoring should only be undertaken by people who wanted to do it and had a genuine interest in nurse education:

“It doesn’t seem to me to make a lot of sense to force somebody to be a mentor who doesn’t want to be.” (HPL7)

It was also important to recognise other contributions in that while not everyone inspires others to learn they may nonetheless be fantastic nurses.

In taking mentorship forward as a specialist role, the following points were made: interest alone would not be sufficient to recruit enough mentors to meet student demand; mentorship should become a specialist role resourced with dedicated time and additional pay; and that it would address the challenge of the assessment component of mentorship:

“People...... with the role of making sure that students gain experience and they make the assessment decision because they are advanced practitioners with advanced assessment skills. One of our biggest challenges is that of not getting assessment right.” (HPL2).

Another suggestion for taking specialist mentorship forward included paying people a responsibility allowance to be a mentor with the proviso that continuation in this role depended on an assessment of performance at their annual appraisal.

5.4.4 HEI participants, programme directors: views on the generic/specialist debate

Diversity of views also emerged among the six programme directors, with three in favour of all nurses being mentors, two seeing both sides and one advocating a different approach.

Reasons for favouring the generic role

Reasons in favour included: all nurses having a responsibility to support students with their learning; it was the only way of coping with the mentoring workload; and that many of the qualities required of a mentor are the same as those required of being a nurse, particularly those involving teaching patients. As one of them put it:

“You can’t be a nurse without teaching in any capacity...if you are unsuitable to be a mentor you are unsuitable to be a nurse.” (HPD 6)

Reasons for favouring the specialist role

The two who saw both sides felt that there was a case for making a distinction between the teaching and assessment aspects of mentorship, observing that while all nurses should have the capacity to teach, mentoring now involved assessment in a more refined way and that only some mentors will have the skills to deliver that aspect of the process.

A different approach

The sixth programme director thought that a specialist role would have the advantage of providing greater consistency of mentorship throughout the programme but would not have the capacity to
cope with student numbers involved. Their preference was for a different approach involving teams of mentors:

“I would prefer the umbrella approach – ie. team mentoring with a senior mentor – I think lots of places are doing this. I think that works well if you’ve got a really good senior mentor. Again it’s the senior mentor who will encourage and support the student and the newly qualified and the more junior mentor and give that junior mentor that bit of backbone.” (HPD3)

5.4.5 HEI participants, mentorship programme team: views on generic/specialist debate

None of these three participants favoured the generic approach to mentorship but had differing views as to how it should be taken forward as a more specialist role.

Reasons for favouring the specialist role

One of the programme leaders felt mentorship was not an exciting enough subject to become a specialist career path but making it a hurdle that nurses had to get over before being allowed to take other courses was equally problematic; she favoured a more selective approach as to who became a mentor. The mentorship programme teacher thought that while all nurses should be able to support students and newly qualified nurses, their approach to learning in her experience was one of rote learning without much discussion or critical thinking. Hence a specialist mentor role was required to provide the kind of reflective, flexible support she thought that students needed.

The other programme leader echoed the view of many in that she thought nurses would be better mentors if this was something that they wanted to do; if staff were sent on the course:

“I just worry about how that translates into what message they give students when they are on placement.” (MPL1)

A different approach

The HEI-1 mentorship programme leader also considered the distinction between supervising and mentoring students which all nurses should be able to do and assessing student progress which she thought should be a specialist role. Her preference was to return to the system of separate assessors on two grounds: first that assessment requires a lot of decision-making skills which not all nurses understand; and second it would separate the assessment from the support and facilitation aspects of mentorship thus enabling students to feel more relaxed. At present students reported that they felt under scrutiny all the time.

5.4.6 HEI participants, senior educationalists: views on generic/specialist debate

The same picture emerged from the senior educationalists in that none favoured the generic approach to mentorship. They all advocated restricting the role of mentor to fewer people:

“I think we would be better served by a smaller number of excellent mentors supporting a larger number of students than hundreds of mentors, many of whom are poor quality all supporting one student each.” (HSE1)

A second participant was concerned about the generic nature of mentorship being linked with promotion:
“....which to me is the worst possible way of wanting to be a mentor, which I think is evidenced by the fact that there is unfortunately quite lot of poor mentorship out there. I think it should be people who really want to pass on high quality nursing standards and both practice and theory. So I think it should be people who want to do it and then are facilitated by their managers to do the programme and to be given the time then to mentor students.” (HSE5)

Another advantage of the specialist role was having students allocated to the same senior mentor throughout the course to facilitate continuity; a course of action that might be frustrated however, by the high turnover of clinical staff. One of the group argued that the only way that generic mentorship would work was for it to be much better managed with the setting of performance indicators for standards and quality which would then be reviewed at appraisals and performance development profile meetings.

Another pursued the distinction between facilitating learning and assessing competence in some depth maintaining that the pressure on everyone to be a mentor had perhaps devalued and debased the role and that it was time to take a step back and think about it differently. She argued in favour of all nurses having a role in facilitating learning, teaching competencies and skills, and preventing dangerous practice, and having a couple of study days to this end. But assessing competence was a much more complex process than was generally recognised; moreover placements were too short to develop a relationship with a student and have sufficient knowledge and confidence to assess them. Hence assessment should be a specialist role taken on by a few staff. Her preferred model was one of longer placements and for each student to be allocated a personal tutor with a clinical supervisor role (a senior mentor) to whom they would be allocated for the whole of their programme. In the course of longer placements, students would be supervised by secondary mentors who would feedback on the student’s progress to the senior mentor who would also act as the student’s sign-off mentor.

5.4.7 Key points on generic versus specialist approaches to mentorship

- Considerable diversity of view existed among the 37 participants about whether mentorship should be a generic or specialist role. Moreover, a wealth of information was provided on the perceived advantages and disadvantages of different positions and a range of models offered for future directions in mentorship.

- Some interesting associations emerged between the different groups of participants. It was of note that the senior educationalists in the two kinds of organisations held opposite views with those in the trusts favouring a generic approach and those in the HEIs a specialist one. Of those closest to practice, the PEFs, most favoured the specialist route i.e. the same position as that of the HEI senior educationalists rather than that of the trust senior educationalists. Of the other groups, those involved in the mentorship programme were not in favour of the generic route, while a diversity of view existed among the programme directors and lecturers with a link to practice.

- At the heart of this question was an inherent difference of view as to whether being a mentor was an integral part of being a nurse. For some it was part of our professional responsibility’,
‘an inherent quality of being a good nurse’, whereas for others it was not and that staff could be excellent nurses without the desire or aptitude to be mentors.

- That mentorship was often linked with promotion and regarded as a gateway to further courses was seen as not necessarily the best basis for taking on the role.

- Quantity and quality issues were raised. There were concerns that only the generic route would provide sufficient mentors to match student numbers. Benefits of mentoring to nurses’ own professional development were enumerated but also countered with having to take on a role that might be unwanted. Much of the concern about the generic route focused on mentor’s abilities to assess competence and this was the focus of many of the alternative approaches advocated. It also lay behind the decision to introduce sign-off mentorship.

- Various suggestions were put forward as to how a specialist mentor career pathway might be developed along with some of the challenges that this might present. Furthermore, alternative ways of addressing the provision of mentorship were proposed.

5.5 Sign-off mentors: rationale for introduction

While mentors have a long history, sign-off mentors are a more recent phenomenon. Brought into being by the NMC standards of 2006 in response to concerns over incompetent practice not being addressed (Chapter 1, Section 1.4), the trusts were at a relatively early stage of introducing sign-off mentors at the time of fieldwork in late 2011. Participants were asked for their views on the rationale for the policy (34 replies). Responses revealed common themes and some variation between groups of participants as shown below.

5.5.1: Trust participants, senior educationalists: rationale for sign-off mentors

Of the seven trust senior educationalists, one did not respond to the question and another expressed uncertainty:

“I don’t know, I can’t really think about that one to be honest.. I don’t think it makes complete sense but I’m not sure why, I’d probably have to think about it.” (TSE3).

Others were positive about the rationale, identifying benefits as: making sure that newly qualified nurses are fit to go on the register; protecting the public, and locating accountability for this decision firmly with the nursing profession:

“It certainly helps to take ownership in that if the clinicians who are making judgements about competency are faced with outcomes in the sense that the person could then be working alongside them and so it helps to focus much more on should I or should I not allow this person to get to this point.” (TSE7)

“I think it’s a good idea. It focuses responsibility on signing someone off - this person is going to go on the register and they’re going to be exposed to the public, we need to protect the public. So I really do agree with sign-off mentors.” (TSE6)
Observations were made about implementation of the policy: incompetent practice should be picked up at every stage of the course and not just during the final placement; and investment was needed in terms of support and supervision to ensure that people fully understood the implications of signing someone off as fit for practice.

5.5.2 Trust participants, PEFs: rationale for sign-off mentors
PEFs saw sign-off mentorship in practice and of the eight, five viewed its introduction in a positive light. A diverse range of reasons were cited: making staff more questioning of students’ abilities in their final placement; raising the profile of mentorship; placing more emphasis on the preparation of mentors and on the judgements they make; looking at the students’ development over the programme as a whole; having decisions about competence being made by the most senior and experienced mentors; and providing a career path from mentor to sign-off mentor to practice teacher. One of the five said that while agreeing with sign-off mentorship in principle it was idealistic in that sign-off mentors did not get the protected time required:

“The framework I thoroughly agree with. The actual implementation practically is impossible.” (TPEF5)

Of the other three PEFs, two responded in terms of the NMC having to introduce sign-off mentorship in response to employers’ concerns that newly qualified staff were not fit for practice, with one expanding thus:

“In some ways this is sad ..because since we moved into HE, nurse education is more like a business than a vocational aspect of work. Universities are basically looking at income just like any other business and people have been qualifying when they are not fit for purpose. So the NMC had to introduce sign-offs to ensure quality.” (TPEF2)

The third expressed concerns in that she thought some mentors were not very good and could not see how the introduction of sign-off mentors would improve this situation.

5.5.3 HEI participants, programme directors/lecturers with practice link: rationale for sign-off mentors
In the main, participants with a direct involvement in the pre-registration programme as link lecturers and/or programme directors (n=13) spoke positively about the introduction of sign-off mentors. As with trust participants, comments focused on: ensuring that students were fit for practice; on protecting the public; locating accountability for decisions about competence within the nursing profession; and on making mentors aware of their accountability in this respect:

“It’s a great rationale in that the person making the decision that someone is competent to go on to the register needs to be absolutely clear that that is what they are doing…. it came in because mentors didn’t understand their responsibility as gatekeepers to the profession and now that’s been made very clear to them.” (HPL2)

“The fact that it can be trailed back to once they qualify, if you say this student’s wonderful and all of a sudden they find they’re completely lethal, then I think people are more worried about that.” (HPD3)
Other positive outcomes of introducing sign-off mentorship included: getting final destination students to understand what it means to be a registered nurse; ensuring that third-year students are able to make the jump towards being able to manage other people and to take responsibility for decision making; enabling someone to have an overview of the student’s progress and to identify any remedial actions that are required; providing support for other mentors in the same practice area as the sign-off mentor; and raising the profile of mentorship. One added a rider that although sign-off mentorship was a good idea, it was rather sad that it had to be introduced as it was in response to the perception that some students were not sufficiently fit for registration.

Two members of this group felt that the introduction of sign-off mentorship had highlighted that ensuring students were fit for practice was a joint HEI/service responsibility. Thus one found it reassuring that when she came to sign-off the ‘declaration of good character’ for the NMC she could look at the student’s portfolio and see that someone close to the students’ practice had also concluded that the student had reached this position. In the words of the other:

“It’s good in that responsibility for ensuring that students are fit lies with both sides. The HEI is saying that the student is theoretically fit for purpose but we can’t say that they are clinically fit for purpose as we are not assessing them. The role of the sign-off mentors enables the NMC to reinforce that responsibility for clinical practice lies with you. So practice can’t say any longer that we have a poor quality pool of staff nurses. It reinforces that mentors are accountable for decisions about students’ competence.” (HPL5)

Just two of these 13 participants expressed concerns about sign-off mentorship: one thought that it was frustrating for students to work with mentors who could not sign them off and a second that the task of signing off three years of a student’s work, probably not having met them previously, was a considerable challenge.

5.5.4 HEI participants: mentorship programme team and senior educationalists: rationale for sign-off mentors

The other two groups of HEI participants, the mentorship programme team (n=3) and the senior educationalists (n=5), made positive (6) and negative observations (4) about the introduction of sign-off mentorship. Positive views echoed many of those made by other groups of HEI participants and trust colleagues: namely, concentrating accountability; having decisions about student’s competence made by practitioners; someone having an overview of the student’s progress as a whole; and ensuring public safety. Concerns focused on the implementation of sign-off mentorship and more broadly on the concept as a whole. The former included: the onerous nature of the role; that a two tier system might result as mentors may give students the benefit of the doubt knowing that the final assessment will be made by a sign-off mentor experienced in assessment; and hence a tendency to leave decisions about failure to the end of the course. Two participants, both with a practice overview brief, expressed concerns about the concept as a whole. For one, the fact that in midwifery all mentors were sign-off mentors ‘makes the whole thing a nonsense’ while the other thought that it was confused and vague.
5.5.5 Key points on the rationale for the introduction of sign-off mentorship

- The majority of trust and HEI participants spoke positively about the introduction of sign-off mentorship with a focus on: increased accountability for judgements about fitness for practice; locating decisions with experienced practitioners; and ensuring public safety.

- A wide range of other benefits were cited for students, for mentors, and for the way in which mentorship is perceived.

- A few, however expressed regrets that sign-off mentorship had had to be introduced and a minority expressed concerns; these addressed feasibility of implementation, dangers of identifying problems too late in the programme, and the value of the concept as a whole.

5.6 Clarity over requirements for becoming a sign-off mentor

A question to all participants asked whether they thought there was clarity over the requirements for becoming a sign-off mentor. Our interest lay in whether the NMC guidance was regarded as clear; however, the question was interpreted in two ways, either referring to the NMC guidance and/or to whether the HEI and service staff understood what was required. This dual interpretation had not emerged during piloting as necessitating clarification and hence both forms of responses are presented here (31 participants responded).

5.6.1 Trust participants: views on clarity of requirements

The senior educationalists who responded (5) focused on clarity of the NMC requirements while the eight PEFs were more likely to focus on whether staff were clear (6) than on the clarity of the NMC requirements (4).

Clarity of NMC requirements

Of those trust participants (9) who referred to the clarity of the NMC documentation, one observed:

“\textit{I’m not sure that the NMC provides specific detail of clarification. They tend to give you guidance and then it’s up to you to interpret and implement it.}” (TSE2)

All the others thought that the guidance was clear with one adding that the length of the documentation was off-putting to busy staff:

“\textit{They are [clear] if like me you have time to read the kind of tome the NMC tend to produce. But for mentors they shut off and can’t be bothered to read it all.}” (TPEF7)

Staff understanding of the requirements

Six of the PEFs described staff reaction to the NMC guidance; this was most likely to be one of confusion but mention was also made of anxiety. One PEF explained that there had been a lot of confusion in the trust for the first 18 months over what they needed to do and whether there would be annual sign-off mentor updates and that this had persisted despite the best efforts of the PEF and other senior people to brief people. Anxiety on the part of staff was attributed to the perception that becoming a sign-off mentor entailed taking on a lot of additional responsibility.
5.6.2 HEI participants: views on clarity of requirements
A more diverse set of responses emerged from participants (19) in the two HEIs and, as the following account shows, diversity existed within rather than between the different groups of post-holders.

One of the senior educationalists responded to the dual nature of the question thus:

“It’s clear what the requirements are: on the mentor register, up to date and full understanding of their accountability and the programme and have practised 3 signing offs which two could be in class. It’s very clear what the requirements are - whether or not that means somebody is suddenly going to become more aware, I don’t know.” (HSE1)

Clarity of NMC requirements
Other HEI participants (11) who referred to the clarity of the NMC guidelines had very differing views. As to be expected both the mentorship programme leaders said that the NMC standards were clear, with one adding that they were probably much clearer than several of the other NMC standards. In contrast, the three programme directors were unsure although it could be argued that this was not part of their remit. Four lecturers with a practice link responded thus: one said that the standards were absolutely clear, another thought that they were not, the third did not know and the fourth regarded them as confusing in that they started by specifying that three assessments had to be observed in practice and subsequently stating that two could be undertaken by other means. One senior educationalist thought that the standards would be clear but personally was unsure about them while another member of this group regarded them as confusing.

Staff understanding of the NMC requirements
With regard to responses concerned with peoples’ understanding of the requirements, differing perspectives emerged among the senior educationalists. For one it was an observation that trusts varied in their understanding while another was unsure of whether people were aware of the requirements. A third couched her answer in terms of what sign-off mentors themselves should be clear about:

“Well I think understanding of all those processes involved in assessment. And an understanding of the legality of what you are doing. Of the risk that’s entailed in what you are doing and then a kind of exploration of the supports that you might need to have in place in order to be able to do that role.” (HSE3)

The fourth focused on anxieties that had been engendered by sign-off mentorship:

“Nobody understood what the NMC really wanted and how it would be applied in practice…. I think it slowly dawned on nurses that actually as a sign-off mentor you were saying this student was fit to register, a lot of them became frightened at that point because they were realising their names, were going to be identified by the NMC as somebody who signs somebody off.” (HSES)

One of the mentorship programme leaders described making sure that all members of the module teaching team understood the requirements and found that some learner mentors came without an understanding of what sign-off mentors do and the nature of their responsibilities. In the experience of one of the programme directors, mentors understood the process of becoming a sign-off mentor but were unclear about the subsequent responsibilities of this role.
5.6.3 Key points on clarity about NMC requirements for sign-off mentorship

- Most trust participants thought that the NMC requirements for sign-off mentorship were clear, perceptions were much more mixed among their HEI counterparts.

- Both groups reported considerable uncertainty among practice staff; Section 5.8 includes findings on the work that trust and HEI participants undertook to increase staff understanding.

5.7 Desirable qualities for sign-off mentors

Having explored the rationale for the introduction of sign-off mentors and clarity over requirements for the role, participants were asked what qualities they thought that sign-off mentors required (usable responses were obtained from 13 of the 15 trust and 19 of the 22 HEI participants). In order of frequency, the qualities cited were: experience (17); knowledge of professional requirements (9); skills (8); attributes (8); confidence in judging competence (8); supporting mentors (6); and understanding principles underpinning judgements (5).

Experience

While some of the participants in this group talked about the need to be experienced practitioners, most focused on needing experience as a mentor. Those highlighting particular aspects of mentoring experience referred to: learning how to manage students in practice; being able to deal with complex issues; and being able to recognise when students do not have all the required competencies. One HEI participant observed that while personally regarding experience as a mentor as important, this was contradicted by the situation in midwifery where all mentors were sign-off mentors.

Knowledge of professional aspects of nursing

Nine participants (8 HEI and 1 trust) said that sign-off mentors needed to know about professional standards in nursing; these included the NMC standards for mentorship and sign-off mentorship and the NMC requirements for registration as a nurse. The importance of a good knowledge of the curriculum was also cited. One of the lecturers with a practice link summed this up as:

“A good knowledge of the curriculum, what does it mean to be a student in final placement and what does it mean to actually help to prepare the students to be a registered nurse.” (HPL5)

Skills

A wide range of skills were identified as essential qualities for sign-off mentors. Good communication and interpersonal skills with students appeared most often and good communication with the PEF about the student’s progress was also mentioned. Other skills included: supporting the student in skill development; demonstrating how students have increased their analytical and decision making skills; providing constructive feedback; celebrating people’s strengths with them; identifying areas that need further development; prioritising and planning action with students; carefully considering their progress; thinking flexibly about remedial action needed; and managing difficult situations such as behaviour regarded as unacceptable by the third year. Another observation was that sign-off mentors have to be able to stand back and recognise that students who appear over confident might be covering up a lack of competence and that
students who keep a low profile may be lacking in confidence or have not achieved the required competencies.

Attributes
Attributes that were regarded as desirable for sign-off mentors included: having an interest and aptitude for teaching; being self aware and reflective; being fair, consistent, encouraging and thoughtful towards students; and having a high level of commitment in view of the requirement of a one-hour meeting every week throughout the placement. Expectations to be held of students were also cited; these needed to be realistic and recognition that students would not necessarily have the same qualities as themselves:

“...not just wanting the student to be a version of herself but to recognise that the student may have other qualities that can be built on once registered and would be a different type of staff nurse to her but an equally valuable one to the profession.” (HPD4)

Confidence to make judgements about competence
Eight participants (mainly trust) focused primarily on the confidence to make judgements about students’ competence. Comments by trust senior educationalists indicated that this required self assurance and an awareness of the responsibilities entailed:

“They need to be experienced members of staff, they need to be sufficiently self assured to have the confidence to be able to say that they are not happy about signing a student off and be able to articulate and rationalise their reasons. Not to be easily influenced and will do something for an easier life.” (TSE5).

“They need to have confidence and to be discerning because ‘you as a sign-off mentor are saying to the profession I have worked with this person, I know their strengths, I’ve got a measure of their capability and I am now going to release into the work stream another person that’s safe. So it’s a very serious responsibility – as the sign-off mentor has the opportunity to say whether someone is ok or ‘maybe this person needs another three months in a particular area’. ” (TSE1)

Understanding of governance, accountability and legality of position
Other respondents took up the theme of sign-off mentors understanding the responsibilities, accountability and principles entailed in making judgements about competence as the following examples show:

“Understanding of governance processes is an absolute requirement. An understanding of the legality of what you are doing. Of the risk that’s entailed in what you are doing.” (HSE3).

“I would hope that all mentors realise the importance, the enormity of what they are taking on.” (TSE6)

“And they need to be very conversant with the principles of fair assessment.” (MPL2)

Support oneself/supporting others
Five participants (all HEI) described supporting colleagues with mentoring as a desirable quality of the sign-off mentor. This included support for registered nurses who wanted to become mentors,
those who had recently qualified as mentors, and mentors who wanted to become sign-off mentors. In relation to supporting junior mentors, one of the programme directors made the point thus:

“In being able to turn and say to their junior mentors ‘actually you can’t sign that off because of what you are telling me’. It’s just being fair. It’s being impartial and non judgemental. This is where they’ve got a really important role because some of the more junior mentors can come down to ‘do you like the student or not’.” (HPD3)

**Key points on qualities required to be a sign-off mentor**

- Participants identified differences in qualities required by sign-off mentors compared with those required by mentors. Although a range of skills to facilitate learning were also identified, there was a greater focus on making judgements about competence and on an understanding of the wider principles underpinning these judgements and of professional matters more generally.

- Associations between responses and groups of participants showed that trust participants were more likely than their HEI counterparts to focus on having the confidence to make judgements about competence whereas a higher proportion of HEI than trust participants focused on a knowledge of nursing standards more generally, and on supporting colleagues with mentoring.

**5.8 Process of introducing sign-off mentors**

All participants were asked about the processes involved in introducing the policy and getting sign-off mentors into post. Responses covered initial discussions and decisions about taking the policy forwards and work at ground level on informing staff about the policy and nominating and training individual mentors. Perceptions of how the process had progressed as a whole were discussed as were specific challenges that had been encountered.

**5.8.1 Initial discussions and decisions**

Participants in both HEIs described initial work undertaken to inform trust colleagues about the requirements of sign-off mentorship. At HEI-1, participants said that staff had spent a lot of time discussing the process with trusts and getting over the message about the difference between mentors and sign-off mentors; the Practice Education Support Unit had put together a set of resources about sign-off mentorship upon which trusts could draw. At HEI-2, one of the senior educationalists described a series of presentations to key HEI staff followed by a road show to the various departments in the trusts they linked with accompanied by discussions with the nurse in charge at each.

Some of the PEFs and the practice-based link lecturers described the procedures that they had developed to inform colleagues about sign-off mentorship such as making notes on the requirements to give to staff; visiting all the key personnel; writing articles for the trust newsletter; including the topic in mentor updates; and sending sign-off mentors reminder notes when they had their first final destination placement. One of the HEI programme directors attributed the smooth implementation of sign-off mentorship in the trust they linked with to the work of the PEF in preparing trust staff.
Participants at both HEIs said that criteria for becoming a sign-off mentor was a trust decision and that policies had varied in this respect; examples were given of trusts that had said that everyone at Band 6 should be a sign-off mentor and others opting for making all mentors sign-off mentors. In relation to the former policy, a PEF working in one such trust had said that there had been little response from managers when asked to designate which of their staff could become sign-off mentors; hence the trust made a blanket decision that all staff at Band 6 would take on this role. In a primary care trust, it was decided that all community practice teachers would be designated as sign-off mentors. Decisions about which individual members of staff in each practice area should become sign-off mentors were made either by the PEF, or by the PEF and the HEI link lecturer jointly where the two worked closely together; one link lecturer described the latter thus:

“We have to look at it with the trust, is it viable for everyone to be a sign-off mentor? Do you need that many sign-off mentors at this point? It’s got to be in discussion with them.” (HPL1)

One HEI participant with a practice link however, said that in a transition period between PEFs, she had taken responsibility for nominating the mentors whom she thought were suitable to be sign-off mentors.

5.8.2 Providing training for sign-off mentorship

There was also variation over which staff were involved in running the training for sign-off mentorship, a training that comprised attending workshops and being observed while making a judgement about competence of students in their final destination placement. In some trusts in the study, the PEF described running the sign-off mentor workshops themselves; in others they described joint working with HEI staff. This joint working was corroborated by a link lecturer who described running courses in a primary care trust with the trust education lead. In the trust which had had a break in having a PEF in post, the HEI practice link had taken on the task and had run some 30 workshops attended by over 200 mentors.

The independent sector provided challenges of its own with staff in the nursing care home component of this sector scattered over a wide geographical area and managers and mentors initially reluctant to take on the responsibilities of sign-off mentorship although happy to take first and second year students. An HEI participant who linked with this sector stressed that more work was needed in selling the concept of sign-off mentorship to nursing care homes as a worthwhile activity in which they should be engaged and described the system that they had devised to this end with the support of the home managers. A good mentor who wanted to be a sign-off mentor was placed in a home with an established sign-off mentor from whom they could learn and be supervised. Once the three supervisions were complete they returned to their own home and became established as a sign-off mentor themselves. In time the link lecturer then brought other mentors to learn from the second sign-off mentor. This policy was adopted for a cluster of homes at a time. This participant observed that this work went beyond their role and remit as a link lecturer, but undertook it on the grounds that it was an investment in the long term for the HEI as the more sign-off mentors available in the independent sector, the wider the range of settings in which final destination students could be placed. If the number of mentors and sign-off mentors were to be increased sufficiently however, this participant said that a designated person was required to oversee this process and that it could not be dependent on a single link lecturer in the long run.
Community settings provided similar challenges of scattered sites and small numbers of final destination students at present. A PEF for one of the primary care trusts stated that the trust had to have sign-off mentors and it was up to her to get some of those on her mentor register through the sign-off course with the aim of having at least one, ideally two in each setting. But demands on her time and that of the mentors made it difficult to achieve even with input from the link lecturer.

The challenges of demands on staff time frustrating the drive to ensure sufficient numbers of sign-off mentors was described by the senior educationalist and the PEF at one trust as well as by their HEI practice link. The senior educationalist observed that while staff came to the half day training session, many did not complete the workbook that drew together the evidence that they had completed three supervised assessments.

“...there are other demands in the clinical areas, they have staff to manage, they have scenarios, they have very, very busy shifts so it can be difficult...they were committed to come to the classroom...but going away and sitting down and taking out the time to do it this was the challenge.” (TSE2)

From the HEI lecturer’s perspective, the frustration lay in having no authority herself to insist on the workbook’s completion and return. Following an amnesty, a second chance to complete the workbook and the appointment of a new PEF to provide support with the process, the numbers successfully completing began to rise.

Changing requirements for all the supervisions to be undertaken in practice being replaced with some undertaken in the format of classroom-based scenarios, together with views about the impact this has on the time taken to qualify as a sign-off mentor and its robustness or otherwise are discussed in Chapter 7, Section 7.8.

5.8.3 Success in getting sign-off mentors into post

Participants were asked how well the process of introducing sign-off mentors had gone and responses varied in detail and depth. Two HEI participants expressed uncertainty and two had heard that there had been difficulties. The largest group (14) however which included HEI and trust participants from Groups A and B said it had gone well in the main, with some adding a rider that they at least had not been aware of any problems and others that it had gone well after a slow start.

“The process of introducing them has gone well. I don’t think anybody has turned a hair which is interesting and maybe it can be done and I’m over cautious and it can be done.” (HSE3)

A further three participants drew a distinction between the introduction of first and second wave sign-off mentors. The first wave had gone more easily since these were the more experienced mentors; as a primary care trust PEF put it:

“The first wave went well because we had a lot of experienced mentors – who were experienced practitioners, community matrons, community practice teachers.” (TPEF4)

A facilitating factor in a mental health trust was allocating all third-year students to a clinical supervisor who also acted as their sign-off mentor.
The challenge lay in training the less experienced mentors to assume the role; however the proposed change in introducing simulated assessments as opposed to direct observation in practice was identified as making this process easier in the future.

“Our new competency portfolio to be introduced in May 2011 will reduce the burden on practice educators to do all the observed assessments as we are including in the portfolio that assessment can be simulated.” (MPL2)

One of the HEI participants stressed the importance of advance planning on the part of the trust personnel; they needed to think through for each area that was expecting final destination students whether there were sufficient numbers of sign-off mentors in place; a situation she felt was not always the case. Looking at this from a trust perspective, participants highlighted the importance of the PEFs detailed knowledge of practice settings for advance planning. As one PEF put it:

“You know as fast as you train people up there’s issues where people have either moved, or they’ve gone onto new jobs, or they’ve got promotion so they say ‘Oh I don’t really think I can have students in this new role’. So it’s kind of keeping ahead of all that and we’re kind of very focused (on it).” (TPEF7)

And another:

“You get the odd one leaving and you’ve just spent all that time preparing them. It’s most frustrating. So then you have to think about well okay what I would tend to do then is try and find someone else in the department and then I will supervise them while they’re learning to sign-off.” (TPEF6)

5.8.4 Key point on processes involved in introducing sign-off mentors

- Introducing sign-off mentors was a fairly resource intensive affair entailing: providing information about the new policy and its requirements; making decisions about which staff would become sign-off mentors, and providing the requisite training.

- Challenges were encountered in developing sign-off mentors in small scattered settings, having sufficient time to provide and take the training, and having relevant information to facilitate advance planning of the numbers required in specific settings.

- The role of staff who were practice-based as PEFs or link lecturers was shown to be pivotal in: informing colleagues about the policy and its requirements; making or contributing to decisions about which staff should be put forward for sign-off mentorship; providing the training; and keeping aware of changing staff circumstances so that new sign-off mentors could be developed to maintain capacity.

5.9 Responsibility for ensuring sufficient numbers of sign-off mentors

Although participants had described various aspects of their role in establishing the sign-off mentor workforce, they were also asked where they thought responsibility lay for ensuring that this was the case.
**Trust participants: views on responsibilities for ensuring enough sign-off mentors**

Most of the trust participants regarded it as a trust responsibility to ensure that there are enough sign-off mentors. The PEFs and the senior educationalists identified the day to day responsibility as lying with the PEF; thus:

“Ensuring enough is a trust responsibility and through the cascade system comes back to me as the CPF.” (TPEF2)

With some adding that ultimate responsibility lay with a senior manager, for example:

“The PEFs work with me to ensure there are enough mentors in the first place to draw sign-off mentors from.” (TSE7)

“The DN has ultimate responsibility but he expects me to keep an eye on it and alert him to the issue if there are not enough.” (TPEF7)

One of the senior educationalists said it was a joint trust and HEI responsibility but when asked for details, only described actions taken by trust personnel.

**HEI participants: views on responsibilities for ensuring enough sign-off mentors**

So how did the HEI participants see this issue? Of those responding from HEI-2, one thought it lay with the HEI alone, but most described it as a joint responsibility, focusing in particular on the HEI responding to the PEF’s detailed knowledge of staff plans:

“Also PEFs know when a sign-off is leaving and say we need to sort out another – it’s a partnership between the clinical areas and the HEI.” (HPD3).

“I think its joint between the HEI and trust, we need to look at it with the CPF because some of the older sign-off mentors are retiring and we need to discuss whether we need to put strategies in place to try to encourage people to become sign-off mentors rather than just enforcing it upon them.” (HPL5)

One of the HEI-1 participants said it was a trust responsibility but most, like their HEI-2 counterparts, regarded it as a shared responsibility; one of those with a practice focused post said:

“Responsibility is shared with the education lead – it works very well. We checked every pep [placement environment profile], looked at how many sign-off mentors there were and whether we needed more in certain areas. It does go to pot a bit when they keep moving sign-off mentors around, so you have to re-evaluate as you go along.” (HPL1)

One of the HEI-1 participants approached the question slightly differently, maintaining that it should be a trust responsibility but ultimately became an HEI responsibility in that the HEI had to demonstrate to the NMC that there were enough sign-off mentors in place to meet the volume of final destination placement students. This could put the HEI in a difficult position:

“Because ultimately the problem is it’s a requirement that we [the HEI] have to ensure that there are enough sign-off mentors that meet this criteria in practice for our students. So that’s our accountability. And yet we have no mechanism to make the trusts... or make the mentors agree to
be sign-off mentors. I don’t think the trust is taking any ownership of this at all. Because they’re not the ones getting penalised if it doesn’t happen. It’s the HEI that gets the penalty.” (HPL2)

**Key points on responsibilities for ensuring enough sign-off mentors**

- There were diverse views about where responsibilities lay for ensuring that there were enough sign-off mentors.
- While trust participants identified the trust, describing the division of responsibility to this end between the PEF and the senior educationalist, most HEI participants regarded it as a joint responsibility citing examples of how this worked in practice.
- Attention was drawn to adverse implications for the HEI at NMC visits if there was lack of clarity over where responsibility lay.

**5.10 Should all mentors be sign-off mentors**

Participants were asked if they thought that all mentors should be sign-off mentors. In some respects this proved difficult to answer as a stand alone question since it linked to their views about the rationale for introducing sign-off mentors and the qualities that they felt sign-off mentors should possess. Four kinds of responses were given: only some mentors should be sign-off mentors; all mentors should be sign-off mentors; mentors should have a choice over the matter; and the question should be approached differently.

**Only some mentors should become sign-off mentors**

The largest group of participants (19) thought that not all mentors should be sign-off mentors but rather that the role should only be undertaken after experience as a mentor. This view was amplified in various ways: Experience needed to be demonstrated:

“I think those that express an interest, have the capability and desire to do it, have shown to be good mentors, have got good feedback from students, then why not really.” (TSE3)

Confidence needed to be developed in making assessments before reaching the point of signing off someone as competent to be on the register. Seniority and experience of managing people was also desirable:

“– need to be managing a team and so actually understands all those issues about managing staff and about looking at areas they need to address – areas where practice could be at a higher standard and so they have that understanding and can have that overall picture when they are signing off.” (HPL5)

Other observations included: mentors should be aware of the importance of being a sign-off mentor as soon as they become a mentor but that time and experience was needed before assuming the role; and that the role required time and effort if taken seriously and hence should be linked into the Knowledge and Skills Framework.

**All mentors should be sign-off mentors**

Ten participants (9 HEI and 1 trust) thought that all mentors should be sign-off mentors. There were several qualifying aspects to their responses. One was on the grounds that it was the only way of
ensuring sufficient sign-off mentors in final destination placements and another that it would only work if they could all have the protected time required for sign-off mentors in the NMC standards. One response presumed a generic view of mentorship in which all nurses were mentors with all having a sign-off remit so that students could be signed off at points along the year and judgements not left until the end of the year while another presumed a specialist position:

“I think all mentors should be sign-off mentors {but in context of only some nurses being mentors} because it’s silly to have a split. You’re either accountable for your decisions or you’re not. The present split means that mentors can leave responsibility to the sign-off mentor to sort out poor students which is why most students fail at the end of their course not part way through.” (HSE1)

Finally another participant thought that all nurses being sign-off mentors would have to wait until there was greater consistency in the content of mentorship courses and greater unanimity of view in the profession as to what mentorship is and what it should be.

Having a choice
For three participants, the question was one of choice; while not opposed to the idea that all mentors should be sign-off mentors, individual mentors should have the choice whether to take this step or not. One added that potential should be encouraged:

“In an ideal world we should first encourage those who have an interest in being a sign-off mentor but we need to ensure that there are enough. There are some staff who would make brilliant sign-off mentors who have never thought about or don’t think they can do it and we need to encourage them to stretch themselves and do it.” (HPD2)

Alternative approaches
Two participants referred back to earlier views that the system of mentors and sign-off mentors should be replaced with a team approach in which mentors fed back information on students’ progress to a key mentor who made assessment decisions. One added that this would be a more positive experience for everyone since at present students felt that they were being examined all the time and mentors were made to feel that their professional decisions were not supported unless they were sign-off mentors.

Key points on whether all mentors should be sign-off mentors
- Responses differed between participants and to some extent reflected views about whether all nurses should be mentors. A higher proportion of HEI than trust participants favoured all mentors being sign-off mentors.

- Challenges with both positions were raised: sign-off mentorship requires experience and if all mentors are sign-off mentors then not all will have had time to gain this experience; and if mentors are not sign-off mentors then there may be problems about assessing student competency during the progress of the course.
5.11 Observations on findings as a whole on mentors and sign-off mentors

In focusing on mentors and sign-off mentors, findings in this chapter have revealed much about the hinterland to the delivery of mentorship in practice and the resources, relationships and activities that underpin this delivery.

Desirable qualities for mentors indicated an extremely wide range of knowledge, skills and attributes for nurses to possess and highlight the importance of support they may need when first assuming the role; a point explored in subsequent chapters. Studies of students' experiences of mentorship, reviewed in Chapter 2, Section 2.3, show a similar range of qualities perceived as desirable for mentors. There were differences of view and practice as to when nurses were perceived as having had sufficient time to consolidate their own training before taking on mentoring others. It was of note that qualities concerned with facilitating learning featured more prominently than those concerned with assessment of competence. For sign-off mentors, confidence to assess was seen as key and much emphasis was placed on the professions' accountability for stating that individual nurses were fit for practice.

There was considerable difference of view about whether all nurses should be mentors and whether all mentors should be sign-off mentors. Differences focused on the inherent nature of nursing and its relationship to teaching students. Issues were raised of implications for the quality of mentorship and sign-off mentorship provided, in particular assessment of competence and ensuring that capacity was sufficient to meet the volume of students at all stages of their course. Questions were raised about the desirability or otherwise of linking promotion to possession of the mentorship qualification and the appropriateness or otherwise of the introduction of sign-off mentorship. Alternative models were suggested by some participants as to the ways in which staff might best be deployed to facilitate the learning of students and assess their competence and thus confirm earlier findings on the subject reported by Bray and Nettleton (2007). These are all critical questions for the profession to debate and are further pursued in subsequent chapters.

Getting mentors and sign-off mentors to the point of being in a practice setting with the requisite skills was the end-point of a range of processes and activities. For mentors these entailed: assessing numbers and likely numbers in each practice setting; commissioning places; adjusting course places available to meet varying demand; decision-making about which staff should attend the course, and maintaining the mentor register. For sign-off mentors these entailed: current and on-going assessment of numbers needed in each practice setting; informing diverse personnel of the policy and its requirements; and providing sign-off mentor training. The account has demonstrated the complex network of working relationships between and within HEIs and trusts to ensure that these various processes were accomplished and the pivotal role of practice-based staff, particularly PEFs and lecturers with a base in, or close link to, practice. There were some differences of view as to where responsibilities lay for ensuring that there were sufficient numbers of mentors and sign-off mentors. On the whole, findings indicated that remits were being delivered, albeit that some concerns were raised about lack of time for these to be fulfilled and the impact of lack of clarity over responsibilities.
Chapter 6: Mentorship capacity: placement provision and student allocation

This chapter focuses on capacity for providing placements in which pre-registration students gain their practical experience and the procedures by which students are allocated to placements and to mentors. Findings show how components of the mentorship hinterland, detailed in Chapter 4, are deployed in relation to: placement provision and allocation; the particular roles of individual personnel; the linked responsibilities of higher education institutions and trusts; aspects of resourcing; a focus on quality and those aspects of provision that are the subject of debate.

The first four sections focus on the various stages in the process from finding suitable areas to the allocation of each student to a mentor. Participants’ perceptions of where responsibility lies for finding suitable areas in which students can gain practical experience and the processes involved is considered in 6.1. The process of planning how these areas will then be deployed to provide requisite practical experience for each cohort of students across their programme is considered next (6.2) followed by decision-making about the number of students each practice area can support (6.3) and then the last stage of the process, allocating each student to a mentor (6.4). Although the process is presented as linear in order to identify the various stages, the findings showed some degree of overlap and revisiting of previous stages.

The various factors perceived as influencing the availability of placements and mentors are considered in Section 6.5, while Section 6.6 addresses ways of enhancing and sustaining placement capacity. Participants’ perceptions of the extent to which commissioned student numbers match placement and mentor capacity are discussed in Section 6.7. Observations on findings from the chapter as a whole are drawn together in Section 6.8.

One of the key criteria for a practice area being considered as suitable for student placements is the availability of mentors and sign-off mentors, considered in the previous chapter and to which reference will be made as appropriate. Consideration is given throughout to the differences and similarities that emerged between HEIs and trusts, between and within the various groups of post-holders; and between hospital, primary care and mental health services.

6.1 Finding and developing placements: responsibilities and procedures

Participants were asked about the process of finding placements, their perceptions as to where responsibility lay for finding these and the nature of their own role in this respect. All the trust participants commented as did most of their HEI counterparts (senior educationalists 3/5, programme directors 4/6, lecturers with a link to practice 7/7 and a placement allocations officer). In Chapter 4, Section 4.4.2, it was noted that one HEI had had a dedicated placement allocation officer with a support team for some time and whom we interviewed, whereas the other HEI had only just recently appointed a placement allocation officer and who was not included in the project.

6.1.1 Responsibilities for finding placements

A response from one of the HEI senior educationalists summed up the main finding that emerged in relation to responsibilities for finding placements:
“It lies everywhere and nowhere. I mean it really does it doesn’t lie anywhere. That is constantly negotiated.” (HSE3)

HEI and trust participants expanded on this notion of responsibility. Some HEI participants attributed overall responsibility for finding placements to the senior educationalist with a practice education remit and/or to the staff of the placement allocation office. A senior educationalist described their role thus:

“On paper I have responsibility for finding placements but in practice this is undertaken by a team of administrators and the lead lecturer for the [learning community of practice] who works on a day-to-day basis with the PEFs who actually look for the placements. My role would be to formalise this in [one of the committees].” (HSE5)

Programme directors referred to the diffuse nature of responsibility for finding placements; for example:

“There is no one person responsible, all of us are responsible to look and listen out for new placements. That’s all our roles, not just one person’s role…. We are all constantly listening out as are the link lecturers but no one is specifically responsible.” (HPD1)

Another acknowledged that finding placements was part of her role but would have preferred a dedicated post-holder with this remit:

“In an ideal world it would be good to have somebody to whom we could give a plan with suggestion of types of placement and they could go and find new placements and do all the organisation required. A lot of the planning is done by others but it is part of my job and would be nice not to have. But I think it’s part of what we have to do.” (HPD2)

In HEI-1, the placement allocation officer said the post did not involve finding new placements and that this responsibility lay with other HEI colleagues and with the trust PEFs. There was some indication, however, from HEI-2 participants that the newly appointed placement officer did have a role in finding and developing new placements, with the community cited as the current focus of attention.

From a trust perspective, the PEFs described the nature of their role in finding placements while the senior educationalists said that responsibility for finding placements lay with PEFs rather than with them personally but that they liaised closely on the subject.

6.1.2 Finding and auditing suitable areas for placements
Participants gave details of new areas that they had identified, the process of assessing the suitability of the area as a learning environment for students and, in some instances, decisions about which member of the HEI staff would be the link lecturer. Particular attention was devoted to settings where it was felt that there was room for expansion: GP practices; nursing care homes in the private sector, and in the community more generally. They either made arrangements for other staff to assess the suitability of newly found potential placements for students but often undertook this task themselves.
A PEF described the auditing process once a new area had been found:

“Once we know of a new team or new service we would start exploring whether or not there will be capacity for students; for example the staffing profile, the number of mentors. If we decide it’s a good place for students then we do an audit, and start working with the team and the manager.” (TPEF8).

An HEI programme director observed that although there were formal systems for developing placements, and identified personnel with a remit to this effect, informal contacts developed though close working with practice settings meant that they could achieve the process more quickly if undertaking it themselves. Examples of areas being developed included the following:

**GP surgeries:** An HEI senior educationalist described how, despite initial reluctance, general practitioners were beginning to recognise the advantages of having students based in the practice and being able to contribute to patient care with tasks such as taking blood pressures. The placement agreement had been the starting point for negotiations that had included matters of insurance and liability. The practice nurses were also keen on having students and were now taking the mentorship course as part of the practice nursing course. Similar negotiations with GP practices were reported by PEFs.

**Nursing homes:** An HEI link lecturer discussing the inclusion of new nursing care homes in the placement circuit, said that a consideration was whether any of the link lectures were able to include it in their existing workload, particularly given the distances that might be entailed. A link lecturer for the independent sector described the detailed nature of the audit required for a new home that had recently expressed interest in having students. The audit entailed: making judgements about the types of students who could go there; the sort of support they would need; how many students could be placed there and so how many mentors will be needed; deciding who will take on the link lecturer role for the home; and having discussions with colleagues to ascertain whether the home could be included straight away in a hub and spoke model of practical experience or whether its inclusion would have to wait until mentors were in place.

**Specialist mentors:** A link lecturer described finding two specialist mentors who had agreed to be mentors (a cardiac failure and a diabetic nurse specialist) and went on:

“I then had to go out and have a discussion with both these people and do a practice environment profile and then discuss with them the expectations we have of them as a mentor and what they would expect back from us.” (HPL5)

**Community:** A link lecturer for a primary care trust described a broad-minded approach to developing settings in the community:

“Yes, anything I see not being used I will open up. In the community there is more and more we can look at which is not necessarily nursing – not district nurses or health visiting and we’ve got to look at care near home e.g. walk in centres, palliative care, inpatient unit in the community, community hospitals where we’ve got day surgery. Anything I can find we will use as long as it’s linking into a total programme.” (HPL1)
Settings in which nurses were not present raised the issue of ‘due regard’ when auditing the area’s suitability for students. A PEF expressed concern about the NMC dictum in relation to assessment:

“It says ‘other professionals may be used if they are adequately prepared’ and we all think well what does that mean?’” (TPEF7)

Finding new placements was a resource intensive undertaking and this could limit the amount of new areas that could be brought into the placement circuit. For example, at the time of the interview, a PEF said that they had reached saturation point in terms of the amount of time they had available to audit new areas.

6.1.3 Key points on responsibilities for finding placements

- Finding placements emerged as a fairly major pre-occupation for HEI personnel who were constantly on the look-out for new areas to develop.

- PEFs likewise were alert to how new services in their trust could offer practical experience for students.

- Finding placements depended upon detailed knowledge of local services and responsibility was thus diffused among HEI and trust personnel and not located within one group.

- A substantial amount of work was involved for HEI and/or trust personnel in auditing new areas as suitable learning environments and capacity to do so could limit the number of new placements that could be included in the placement circuit.

6.2 Planning placement allocation for cohorts of students

In order for students to be able to fulfil the requirements of pre-registration nursing education, their placements have to be planned across the course of their programme to ensure that they gain the requisite practical experience. The allocation of students to placements involved a broad, or macro, level of allocation and a more detailed, or micro, level of decision making. For example, at the macro level, students would be allocated to community experience in year 2 of the course in a particular trust and decisions would also be made as to which of the practice settings in the community would be included as part of this placement. The micro-level of decision-making focused on the number of students that could be accommodated in each practice setting and to some extent informed the macro-level of decision-making. However, there were some distinctions between these two levels in terms of the personnel involved, the processes involved and views about responsibility for decision-making. Hence this section focuses on the macro level of placement allocation and the next section (6.3) on the micro level. The two groups in this study approached the macro level of planning slightly differently and so are presented separately with some overview observations from both drawn together in Section 6.2.3.

6.2.1 Group A (HEI-1 and trusts 1-3): planning placement allocation

In Group A, there was a dedicated placement allocation team at the HEI; headed up by a manager whom we interviewed. The team’s remit was first to map out the student cohort journey across the available placements for the whole of their course and second to decide where, within each trust, these placements would be based; for example a second year placement of community experience,
a third year placement of experience in an acute setting. Information from some of the PEFs and the link lecturers indicated that the central placement team undertook the first and second stage of this process for the large in-patient trusts but that the primary care trusts undertook the second stage having been given the overall course allocation grid from the central team.

The placement team manager described the first stage as one of mapping and planning the placements that were needed for the whole programme and hence had to be working 3 to 4 years in advance with the aim of achieving a balance of community and hospital placements. On the one hand, it was important to reach the point where all the placements were mapped and checked but on the other the plan could not be too prescriptive since it had to be flexible enough to accommodate changes in service delivery. The move from a dual to a single intake of students each year was proving a challenge in terms of avoiding peaks and troughs of students in practice areas. Drawing on information about student numbers and placement nature and availability, the manager developed grids of placements mapped across the course for each cohort of students and these were then sent to HEI and trust colleagues.

Responses of HEI and trust participants showed how they were involved in various stages of the process and their perceptions of its efficacy or otherwise. The programme directors liaised regularly with the placement manager; as one of them said:

“I meet regularly with x (the placement manager) to review which areas are being used and making sure we are as creative as possible and not overloading one area.” (HPD2)

Another drew attention to regular liaison between the manager and the PEFs to inform the planning:

“x (the placement manager) goes to each PEF a year in advance and asks how many students are you going to have and they plot it out – for this module, this placement how many students are you going to have.” (HPD1)

At one of the regular meetings described in Chapter 4, Section 4.5, the programme heads, the placement manager, other HEI colleagues and the PEFs of local trusts suggested the types of placements that would be suitable at various stages of the programme and how they might be deployed across its course.

Trust senior educationalists regarded mapping of students to placement areas within the trust as the responsibility of the PEF, with them available as a back up if needed. One senior educationalist described how having received the numbers of students that the HEI wished to place, the PEF worked with HEI personnel to map out the details of a placement plan that would meet their curriculum needs. The PEF in question focused on the importance of negotiation in this respect between the HEI and the trust:

“I don’t think any one person should dictate. Obviously once agreed then somebody needs to police it to make sure that it happens.” (TPEF2)
A PEF whose trust received a placement mapping grid from the HEI-1 placement manager said that this was extremely useful for both staff and students. This PEF was firmly of the view that mapping students was an HEI responsibility and wished that the other HEIs with which the trust was associated would adopt the same approach; moreover in the current climate of HEIs competing for places, all the HEIs who used the trust should work together in planning their respective student placements.

Participants working in, or linking with, primary care trusts which were not centrally mapped offered differing perspectives. In one, the link lecturer described close working with the trust education lead over placement allocation within the trust:

“It’s working really well. The education lead we have at the moment has been in post a year and she has made a big difference – the placements are now done up to the summer holidays.” (HPL1)

In another primary care trust, participants perceived a lack of co-ordination over placement planning. The link lecturer thought that more co-ordination was needed between the trust PEF and the HEI placement co-ordinator to ensure an overall picture of what each student was experiencing; at present, there were sometimes anomalies with some students not having had relevant experience by a particular point and yet having had too much experience in other areas. The PEF, however had expressed concerns that liaison with the HEI over placements had not been as good as in the past. This chimed with the placement allocation manager’s perception that community PEFs perhaps lacked support and who went on to say:

“The CPFs are absolutely central because they broker the deal. Particularly with this economic crisis, if you haven’t got them brokering the deal, the whole issue of capacity and mentorship starts to break down. You do have to have somebody within the trust at least being the person who is triggering and reinforcing that fact that we need mentors on the ground. If you take those out of the system and you’ve got no one brokering the deal with more and more people trying to get in and have access to those mentors, you just end up in chaos.” (HPAO1)

6.2.2 Group B (HEI-2 and trusts 4-7): planning placement allocation

Although the new placement allocation officer at HEI-2 was not interviewed, the role and rationale of the post was described by a senior educationalist:

“We’ve just appointed someone who is a sort of placement allocation person and she is mapping the whole capacity issues and mapping the students through the placements. So we’ve got some administrative support within the school that could actually help to take this forward.” (HSE3)

Mapping of students across placements was undertaken within each learning community of practice. The lead link lecturer for each learning community met with the PEFs and mentor representatives to work through the allocation of its students. A senior educationalist described the process as one of mapping out students over a three to five year period so that they could see where there were likely to be peaks and troughs in numbers in clinical areas and so that practice staff and PEFs could start to consider how these might best be managed.
HEI and trust participants had differing views about responsibilities for planning student allocations to placements. Among HEI participants, the new appointment was welcomed: for one of the programme directors the previous system was weak in that it did not provide an overview:

“So our admin processes definitely need to be better in terms of negotiation and having a feel of the whole thing.” (HPD4)

And one of the link lecturers spoke positively about the new post:

“Our placement officer is coming to the meeting this afternoon to bring us up to date with what she is doing and looking at the capacity of areas where she wants to place students.” (HPL6)

Among the Group B trust participants, senior educationalists regarded the process as primarily a PEF responsibility with them available as backup if required. One PEF thought that the previous HEI system for planning placements was inefficient while another expressed concern that while the new HEI post-holder had an important role in identifying gaps in allocations and spreading students more evenly across placements, it would be difficult to take account of the specific requirements of each of the programmes currently run by the HEI.

PEFs’ descriptions of their role revealed some differences in approach. Some worked closely with a trust-based programmes officer/allocations officer who planned out the allocations drawing on information provided by the PEFs; for example about areas that were suitable for students at particular stages of the course and areas that needed a break from mentorship for a while. Another expressed a preference for undertaking the work herself:

“I’m known that I do all the allocations and I send them to the HEI and there is an allocation department who should be doing it, but at the end of the day, if they allocated my students, I wouldn’t be very happy… I don’t like allocating – its boring but at the end of the day, I am happy when it’s done properly.” (TPEF 6)

PEFs’ knowledge of their trust and its practice areas was clearly important in informing the process of allocation. One described it as being creative with timetables for allocation; another recounted allocating students to outpatients when ward capacity was insufficient, with PEFs acting as their long arm mentors. PEFs working in mental health trusts spoke of the need to protect first-year students from certain areas that might be overwhelming and put them off nursing; for example some of the acute in-patient units. PEFs also knew if certain areas needed a break from mentorship for a while due to issues such as staff turnover or a serious incident having occurred recently.

6.2.3 Key points on cohort allocation

- Planning the allocation of student cohorts to placements was a complex matter that sought to achieve a balance between ensuring requisite experience and taking account of current circumstances in specific settings.

- The importance of HEI-trust liaison was essential in understanding the needs and constraints of each and the role of PEFs in providing information about practice settings upon which to base allocations plans was acknowledged as crucial to the enterprise.
There were some differences between HEI-1 and 2 in the way placement allocation was approached and differences between trust PEFs in the extent to which they perceived planning by the HEI as helpful and the extent to which they wished to manage this process themselves.

6.3 Micro-managing allocation of students to practice settings

The micro level of student allocation entailed making decisions about numbers of students each practice setting could support (6.3.1) and negotiating student numbers with practice setting managers (6.3.2).

6.3.1 Making decisions about numbers of students practice settings could support

There were two aspects to the question of how many students each practice setting could support: firstly where responsibility for the decision should lie and secondly, providing information upon which such decisions were based. Perspectives of trust and HEI senior educationalists are considered first followed by those of PEFs and link lecturers.

HEI and trust senior educationalists: views on student numbers per setting

Senior educationalists with a practice education remit in both HEIs said that that decision-making about student numbers should be a collaborative enterprise between service and HEI personnel, both stressing the key role of the PEFs in this process; one put it thus:

“It’s joint – the HEI will audit the area in partnership with the PEF and agree the number. If just the trust is responsible then they may err on the side of caution. If it’s just the HEI, we don’t have the local knowledge about what is possible, for example that a ward is going to close down next week. This is why the PEF role based in the trusts is so crucial to the managing of placements.” (HSE1)

That decision-making should be collaborative was also espoused by most of the trust senior educationalists, highlighting in particular trust knowledge of practice circumstances:

“It has to be a collaborative approach, joint control between the trust and the uni. I wouldn’t be happy if it was just the HEI as they don’t have the day-to-day knowledge and insight of what is happening in the clinical settings such as moving into a new hospital at present – with teams separating etc.” (TSE5)

If the HEI asked for capacity to be increased, consideration had to be given by the trust to whether the increase could be accommodated at the same time as ensuring the quality of the student experience in terms of support and mentorship. Responding to a subsequent question on examples of good practice, a programme leader highlighted such discussions:

“What has worked well is we have close collaboration and discussion about the number of students at every period of time between HEI and our trust colleagues. How many can they take? And we do that a year in advance. I suppose that has worked very well so that they know exactly how many students are coming through.” (HPD1)
Several trust senior educationalists explained how changing circumstances in the service could affect the numbers of students that they felt practice settings could support.

These included changes in local service delivery such as: hitherto separate teams merging; the clinical focus and bed numbers in wards changing; wards closing for refurbishment and patients and staff moved to other wards; staff needing time to absorb service changes before being able to prioritise student learning again; and sudden changes in staffing profiles of settings. Moreover, further such changes were likely in light of wider developments such as trust mergers and new healthcare policies. The resulting task for a trust was described thus:

“What you are trying to juggle here is the short, medium and long term. So within there you’ve got the immediate capacity as wards are constantly changing in terms of their service delivery. One minute a ward is 22 beds, the next minute it’s 18. One minute you’ve got two surgical wards and the next you’ve got one. You’ve got winter pressures coming on board. And then you’ve got the merger going on – so how’s that going to affect services... and then you’ve got the whole healthcare agenda for London and the care closer to home policy. So you’ve got all those things coming in really so it’s quite difficult really. It’s not an easy job.” (TSE6)

Providing the information upon which decisions about student numbers could be made was crucial and here the PEF’s role was central both in accessing the information and presenting this to the HEI. This point was highlighted by both HEI participants with a practice education remit and by trust senior educationalists. One of the latter summed this up thus:

“The PEFs are very experienced and at meetings with the HEI they can negotiate over numbers given their knowledge of the placement capacity re short, medium or long term issues that may affect mentor coverage. They flag these up to me and to their line manager ‘and that’s the beauty of it really – the fact that it’s nice to have someone you can rely on to give us that information and flag up the stuff that needs to be flagged up. They monitor numbers’.” (TSE7)

**PEFs and link lecturers: views on student numbers per setting**

The PEFs themselves described their role in: ascertaining how many students their practice areas could support; liaising with HEI personnel; and the process of allocating students to settings.

Information was obtained at regular audits of placements and keeping close links with mentors, key mentors and ward/locality managers. Maintaining this close contact was more difficult for PEFs with widely spread practice settings and one described having a contact person in each setting with whom she kept regularly in touch about the situation on the ground.

Decisions were influenced by the number of mentors, the number of sign-off mentors in final destination placements, the level of learning required, the nature of the clinical area and making an allowance for leave (annual, maternity and sickness). As well as regular liaison with the HEI about the number of students that could be supported, often at the practice-based meetings (Chapter 4, Section 4.5), one-off meetings were held if a particular problem arose. For example, in relation to a larger than usual cohort, one PEF detailed meetings with the HEI as to how the students could be accommodated in a range of small community settings.
“So we work together with the HEI, so we really, really all need to work together, so it’s vital for it to run smoothly…..We do work very closely together.” (TPEF4)

The link lecturers’ role in determining the number of students that could be supported in the practice areas with which they linked included involvement in placement audits and liaison with the PEF. Factors taken into consideration included the number of mentors:

“So I might have a meeting with the PEF and look at how many students is the area currently taking, how many mentors have they got, can we increase the capacity. And it may be that since we last did that another couple of mentors have done the course and they could actually take perhaps another student.” (HPL6)

The nature of the practice setting was also relevant; for example a link lecturer linking with a mental health trust explained that children in a child and adolescent unit had been overwhelmed by the number of people present and so the student capacity was reviewed and reduced and in the intensive care unit, decisions on numbers of students depended on the severity of the clients’ conditions. The size of the setting was also a consideration; with too many students ‘they were falling over each other to gain experience’.

6.3.2 Negotiations with service personnel over student numbers

The account thus far has focused on discussions between HEI personnel and the trust senior educationalists and PEFs. The PEFs and some of the trust senior educationalists also referred to their direct negotiations over student numbers with ward and locality managers as did some of the HEI staff with a practice link. Discussions entailed reviewing the setting circumstances in relation to student numbers, negotiations over whether the numbers could be increased or decreased, and responding to a sudden change in circumstances.

Trust participants: negotiations with service personnel over student numbers

PEFs provided descriptions of the approach they took in negotiating capacity with practice areas. An example was given of a children’s community nursing team that was down to half their normal number of staff and felt unable to take students; yet experience of their work was regarded as an important component of the child branch students’ programme. The PEF negotiated a reduced placement with the team so that students gained at least some experience of their work. In another community example, the PEF referred to negotiations with community teams to take more students; at one time they were only prepared to take one student per team irrespective of the number of mentors but after 18 months of negotiations they agreed to take one student for every three mentors. While acknowledging that the circumstance of each area had to be kept under regular review over numbers of students that could realistically be supported, the agreed ratio gave the PEF some leeway to be able to challenge areas perceived by the PEF as being protectionist.

When describing the arrangement of student allocations in an in-patient setting, another PEF stressed the importance of an approach based on discussion and negotiation with ward staff who ‘have a lot on their plate’. Operating with a ‘hub and spoke’ model, this PEF would let ward staff know that they were being allocated nine students but that at any one time they would only have six as the group was being rotated through areas associated with the ward (pre-admissions, day surgery
and theatres); each of the nine however would have four weeks on the ward so that assessments could take place.

All PEFs stressed the importance of keeping a regular review of practice areas in ‘their patch’ in order to be aware of, and respond to, changing circumstances. As one PEF observed, staff leave and the new staff who are appointed may not have the mentorship qualification, or the area may be going through changes that make them feel unable to support students for a while. Detailed knowledge of the areas and good working relationships with staff was essential for PEFs to feel able to ask managers for help with changing and unexpected situations and also to respond to managers’ requests for a reduction in numbers.

“I’m pretty aware of what’s happening on the ground so that I can make those decisions. I have those relations with some of the staff that I can say ‘Right will you take a few more for me this time.’” (TPEF6)

“What we have been fortunate to have is quite understanding managers and people who have been in the trust a long time and so you find they understand how to juggle capacity. So sometimes we can call on certain wards and say ‘can you take an extra two people, or can you have an extra one, or can we bring this person in who has dropped off and is coming back on, can they have a placement’. And people will be really willing to do that.” (TPEF8)

Other responses indicated that trust staff took a firmer line with their service colleagues at times. Thus an HEI participant described a PEF’s response to ward staff who said that they could only take one student; the PEF who had an overview of the ward’s circumstances said ‘no you won’t, you’ll take two or three.’ Achieving a balance between supporting practice settings over their perceptions of how many students they could support and the trust’s responsibility to educate nurses was expressed in some depth by a trust senior educationalist:

“….but sometimes it’s a case of a manager says I can only support two students. And you think well no it can be more than that because of the number of staff you have…it’s listening to what they have to say, what their argument is, what their justification is for it. But it’s also looking at we’re here to provide a learning environment, we’re here to support and develop our nurses of the future. If we don’t take part in that then how can we have a say in that? So it’s balancing that argument, understanding what it might be.” (TSE2)

**HEI participants: negotiations with service personnel over student numbers**

Good working relationships also emerged as crucial for HEI staff in negotiating student numbers with practice areas. A programme director who was also a link lecturer described regularly meeting with managers or senior nurses to review the audit figures, and coming to a joint decision about numbers of students in light of the number of mentors, number of beds, and types of experience available. As reported for the PEFs, this resulted in a mutually supportive relationship; on the one hand she could contact managers with a request to see if they could possibly take an extra student or two; on the other hand, the managers could approach her:

“Managers will contact me if they say, we are struggling, can we go down on the numbers? Or if they have more mentors, because I have one area for example that are keen to get more students
in there, so they’re pushing through lots of staff on the mentorship course to try and then get more students. So it’s a two way process.” (HPD2).

Another programme director described being able to work rapidly with trust staff to find alternative places for students when a manager who had said they would take students suddenly realised that they no longer had sufficient mentors to do so. Link lecturers also described the ways in which this mutually supportive relationship worked. Thus one who had earlier described a close working relationship with the trust education lead detailed how they worked together to find a student a new placement if there was a sudden change in the setting circumstances, such as the student’s mentor leaving. A second link lecturer observed that service circumstances could change after the student allocations had been planned by the HEI; these included alterations in a team composition or staff feeling overwhelmed by a new service reconfiguration, and so the manager asked if the allocated students could be placed elsewhere. The link lecturer, the ward staff and other trust staff then worked together to find a new placement. On the other hand, the link lecturer also felt able to ask for help:

“Because I know the patch quite well, for my trust that I link to, I know the areas quite well, so I also know whether they can...I say ‘Hang on minute, you have not been having your full capacity for the last year. Come on, let’s be fair and let’s be equal. I need you to take this student’. And I can have that conversation and they’ll go Yeah alright.” (HPL3)

The trust/HEI relationship was sometimes characterised as ‘push and pull’:

“because its hard sometimes, just to look at numbers on a piece of paper and say ‘well you have 10 mentors therefore you should be able to take this number of students’ because it doesn’t tell you...you might have ten mentors but they might all be part time and how part time? So it’s sort of looking at the whole picture, trying to think of what it actually means in real terms. And I think the ward staff as well ..you know, they will say what feels comfortable or not and I think its nice that’s it a joint decision. But we can push to stretch them a little bit, or they can push back and say, ‘No its been stretched too much, we need to have bit of a break’.” (HPD2)

The process of negotiating with service staff sometimes proved challenging for the HEI participants. Examples included programme directors feeling that some areas could take more students and working with them to see if they could manage a few more:

“I think that some areas are overworked to capacity and I think some areas probably could take more. My honest opinion is I think if some areas were more creative with their off duty then you could balance six students quite easily, but they look at numbers and then they just panic. We have tried, we’ve almost done an off duty for some clinical areas to show that it can be done. It’s just difficult trying to get them to see. Again the instantaneous reaction is ‘We can’t take all these students, we have to cut the numbers’.” (HPD3)

And a link lecturer concerned over why one area with 20 mentors that would only take three students while another with six mentors would take five, felt that excuses were made:
You get a whole raft of reasons as to why capacity can’t be increased. Oh you know there’s so many changes in the service at the moment and there’s so much disruption and we don’t know which wards are...And all the old things get pulled out. And yet I see the bigger picture that the problems in the service are often down to recruitment and retention and how on earth do you expect to recruit good quality nurses if you can’t offer them placements.” (HPL2)

**Having the final say**

Findings showed that trust and HEI personnel usually negotiated successfully over the number of students that practice settings could support. But if there was an impasse, what then? This question was not asked of all participants with a link to practice but those who chose to raise it made some interesting observations. Several link lecturers said that the trust made the final decision and that they had no mechanism for insisting that an area took more students. An HEI and a trust participant offered the view that this was appropriate:

“The PEFs should make the decision as they know the hospitals, the trusts, what the areas are like. They know what the problems are and I think that they are probably best placed to decide in liaison with the manager of the area, how many students they should be taking and then obviously have that discussion with us. We might say can you take another one. But at the end of the day I think it should be their final decision actually.” (HPL6)

And it was this local knowledge that underpinned a trust senior educationalist’s view in this respect:

“I do feel that the final say should be with the trust or the acute or the community environment because you know your service, you know what the demands are there. I don’t think an HEI can dictate that........ Yes they can advise – this is where we need our students to have exposure to, but likewise you are working and liaising with the people in your service who know exactly what can be done and what can’t be done.” (TSE2)

A way forward with such impasses was suggested by a link lecturer who thought that there should be a checklist that allowed matching of resources in the form of number of full-time mentors and acuity of setting with supporting a given number of students. Such a formula would have to be accepted by the HEI and the service provider and would not be negotiable. This proposition was also raised in the context of Section 6.7 which focuses on the broader question of student numbers matching capacity to support them.

### 6.3.3 Key points on decisions and negotiations on numbers of students per setting

- Good working relationships between and within the groups of HEI and trust personnel, emerged as crucial in successful negotiations over numbers of students who could be supported in practice settings.

- Knowledge of local circumstances was recognised by both groups of participants as essential in informing these negotiations.

- Good working relationships between staff in practice and the PEFs and link lecturers who liaised with them were the cornerstone of enabling the flexibility needed to manage changing circumstances on both sides.
While there was general acknowledgement that service staff were best placed to decide how many students they could support at any given time, some irritation was expressed by trust and HEI personnel when they thought that service staff could be more accommodating.

6.4 Allocating students to mentors

Decisions about which student should be allocated to which mentor was the final stage in the process of placing students in practice settings. Various aspects of this process were explored with participants (6.4.1) and given the increasing proportion of students on degree programmes, participants were asked whether difficulties might be presented when non-degree qualified mentors were paired with degree programme students (6.4.2).

6.4.1 Deciding which student should be allocated to which mentor

Participants were asked who made the decision, whether there were any particular criteria that were taken into consideration and the nature of mentorship arrangements in place. Each is considered in turn, with attention drawn to some differences between types of trust.

Personnel making decisions about allocations

HEI staff who had an overview of more than one trust said that decisions were a matter for practice-based staff and most likely the ward, department or locality manager. The same picture emerged from the participants relating to each trust (the trust senior educationalist and PEF and the HEI lecturer that linked with the trust), with additional information provided about the input of the PEF and/or the link lecturer into the process.

In one of the primary care trusts the allocation was made by the PEF, whereas in the other the PEF allocated students to a locality and the locality manager then decided on the allocation of students to mentors. Participants in the three hospital trusts were in agreement that the decision was made by the manager of the practice setting with input from the PEF. In most settings in the two mental health trusts, students were allocated to mentors by the setting manager but in some the students were allowed to choose their mentors. The mental health trust PEFs thought students being allowed to choose their mentor could be beneficial as some students ‘have a feel for who would be a good mentor for them’ but observed that this could present difficulties if the placement was very short. Furthermore the PEFs advised students to contact them if they had not got a mentor by the end of the first week and that they would speed up the process.

Criteria for allocation of students to mentors

HEI participants informed PEFs about students whom they felt had particular needs in terms of the sort of mentor who might suit them best. The most frequent request was for experienced mentors for students perceived to be struggling with the work. On the basis of their knowledge of students’ progress, PEFs also asked practice settings managers to choose an experienced mentor. However one PEF observed that the HEI was not always forthcoming with information about students as this was regarded as confidential.

Other criteria used in allocating students to mentors included: where possible meeting students’ requests to be allocated with a professional in a particular discipline (e.g. a district nurse) as in the past this appeared to encourage retention; ensuring that mentors took it in turn to have a student; and while some mentors were known to be favoured by students it was sometimes important for
students to be taken out of their ‘comfort zone’ and perhaps placed with a more questioning mentor.

**Mentor allocation arrangements**

Various kinds of arrangements for mentoring students were in evidence. There were some differences over the status of co-mentors. Thus in one trust, in settings with insufficient numbers of mentors, students could be allocated to a co-mentor (who was not a qualified mentor but sometimes a learner mentor) as well as a primary mentor but the former’s work would be countersigned by the latter. In another trust, the link lecturer said that it had taken some time on her part to ensure that the trust understood that co-mentors had to be qualified mentors as well. Participants also referred to mentor and co-mentors in the context of a hub and spoke model; thus a student would be allocated to a district nurse mentor but would also have opportunities to see how a mixed team worked by, for example, spending time with a community staff nurse or a nurse specialist, regarded as associate or co-mentors, and who liaised with the student’s mentor about progress. Some settings had a policy of allocating students to two mentors to cover shift patterns and leave, one of whom would be more experienced and support the more junior mentor; this was beneficial for the student and the more recently qualified mentor. One of the mental health trusts had a team mentorship system and the whole team took responsibility for a student whose mentor was not on duty.

Positive and negative observations were made about how well mentor allocation arrangements were working. A senior educationalist with a practice education remit said that arrangements differed from one placement to another with concomitant disparity in quality. Thus HEI staff received some reports from students of mentorship ‘being brilliant’ but also reports for other places that seemed to indicate a lack of responsibility on the part of managers. The latter was evidenced in students’ experiences such as their mentor being on leave or on night duty at the start of the placement or arriving on the first day to find that no mentor has been identified for them. This participant thought that mentorship arrangements worked best in places in which there was an identified person with an education remit, perhaps a PEF, who took responsibility for planning allocations. Another participant confirmed the importance of such a person:

“The PEFs are very, very helpful. A good example, I had a phone call from a student who went to her area and there’s been a mix up with the allocations, so I called the PEF. X sorts it out with the mentors and so on and then gets back to me and it’s fine.” (HPD4)

Some of the PEFs described their role in this respect in that they worked towards every student having a named mentor by the start of the placement and, if possible, making sure the mentor is on duty the day the student arrives.

**6.4.2 Pairing mentors and students who have qualified via different courses**

The increasing proportion of students qualifying via degree courses meant that many students were likely to be allocated to mentors who qualified via a non-degree route, either a certificate or a diploma course. Participants were asked if they thought this might present any difficulties for either party.
Nearly all trust and HEI participants responding to this question thought that non-degree qualified nurses mentoring students on a degree programme should not present any problems. The main rationale for this was that mentors were teaching students about skills that they already possessed themselves but that the student was in the process of gaining. Phrases used to describe the mentor’s superiority in this respect included: ‘the nurse mentor without a degree has more experience’; ‘the nurse is the expert in the field and the student is there to learn’; and ‘the NMC proficiencies attained by qualified nurses are what matters, not the academic background’.

Looking ahead, an HEI senior educationalist thought that as the degree culture increased in London hospitals then more and more mentors would have gained degrees through top-up courses. On the other hand, a trust senior educationalist said she would not be happy if the trust adopted a policy of mentors having to be degree qualified before mentoring degree programme students.

Several participants acknowledged that non-degree qualified mentors could feel anxious about mentoring degree programme students:

“It’s their perception and their self value because they are feeling like the poor relative now and so they are thinking ‘oh I can’t mentor them because I don’t have a degree myself’. They also find it challenging as degree students are themselves being challenged to be more critical and ask questions.” (HPD2)

A trust senior educationalist said that they were finding that graduate programme students were more analytical and challenging and thought that that an experienced nurse with or without a degree who was a good role model could manage such students well, whereas nurses who are less confident might feel undermined. Several participants spoke of the need to allay mentors’ anxieties:

“It’s important to make the mentors feel comfortable about this because they are assessing a skill or competency that they have and that the student doesn’t. I think it’s more of a perception than a stumbling block actually.” (HSE4)

Others described offering advice to mentors as to how to handle potentially difficult situations. For example, mentors needed to recognise that students may not have clinical competence with a particular intervention since the procedure was now approached differently in their course; however, if a student made them feel intimidated by their more recent knowledge then they should point out to the student that such an attitude would also make a service user feel uncomfortable. Advice was also offered to students when they were not clinically competent with a procedure when the mentor thought that they should have been; thus honesty was the best policy – ‘Tell the mentor but do it in a positive and proactive way – say I’m not clinically competent yet but I recognise that this is an opportunity for me to gain that competence’.

6.4.3 Key points on allocating students to mentors

- Decisions about which student should be allocated to which mentor were most often made by the manager of the practice setting or locality.

- HEI and trust personnel’s knowledge of student circumstances and particular learning needs were used to inform setting managers of the kind of mentor who would be most likely enable the placement to be successful for the student.
Diverse approaches were in evidence for mentorship arrangements including co-mentors and primary mentors; team mentoring; and students choosing their mentor.

Emphasis was placed on having a learning environment that ensured that mentorship arrangements were in place to greet the student on arrival and to provide cover when mentors were absent.

6.5 Factors affecting availability and capacity of placements

Having looked at the journey from finding placements to allocating students to mentors, the chapter now turns to factors perceived as influencing the availability of practice settings as placements and their capacity to take students. Participants’ perceptions are grouped as follows: willingness and eligibility to mentor students (6.5.1); changes in service provision (6.5.2); changes in the curriculum for pre-registration education (6.5.3); and issues concerning particular branches (6.5.4); community settings (6.5.5); acute and specialist settings (6.5.6); and sectors (6.5.7). Participants (33) provided responses relevant to one or more of these factors depending on their role in placement management.

6.5.1 Willingness and eligibility to mentor students

Willingness and eligibility of staff to mentor students was perceived as operating at a practice setting and at an individual level. The question of whether the introduction of sign-off mentorship had affected willingness to mentor was also considered.

Willingness and eligibility at practice setting level

In the experience of some participants, certain areas, particularly those with a specialist remit, were only willing to have third year students. One of them, engaged in mapping placements for students referred to ITU:

“There are lots of ITU’s, ‘We only want third years, we don’t want second and first years’, whereas my understanding is that some of the research has very clearly shown that first years get a hugely beneficial experience. But you say that to a person in ITU and they’ll probably have a hissy fit.” (HPAO1)

A PEF who had encountered the same problem in placing students, observed that this would no longer be possible with the new education standards since all placements had to be available for all students and that part of their role had been making this clear to staff across the trust at audit reviews.

Examples were also given of practice settings in the private setting and others within the orbit of general practice who had decided not to support students any longer, entailing a loss of investment in capacity:

“So somebody that we’ve invested in and done the mentor training etc, we can’t use that placement which is really sad.” (TPEF1)

Willingness and eligibility at an individual level

Some participants had made the point earlier (Chapter 5, Section 5.4.2) that not all nurses felt that they had an aptitude for mentoring but nonetheless were very good nurses. Another reason offered
for lack of willingness to become a mentor was that it would be too much on top of all the other competing demands on their time. Nurses who were qualified as mentors were perceived as sometimes being reluctant or unable to use the qualification. In some instances, this was attributed to lack of willingness to take a share of the mentoring workload: as one participant put it using pseudonyms:

“...it’s this thing about ensuring that the pressure of placing the students is spread evenly around everybody. I can never understand how Cynthia manages to sit in the corner and never put her hand up and never get a student, whereas Doreen has had five in a row. You think why does that happen?” (HPAO1)

Reluctance was also attributed to loss of confidence in mentoring through lack of being allocated a student; this seemed a particular issue in community settings when a team might only have one or two students at a time, and for some reason, some team members missed out the allocation. It was thus observed that it was important for community managers to ensure that all their staff had opportunities to use the qualification and several PEFs observed that opportunities to facilitate this will increase as the new curriculum includes community experience for first year students as well.

Capacity was also reduced when staff moved into roles which precluded having time for mentorship and one of the PEFs making this point felt that the mentoring experience of these staff could and should be used:

“If you think about the matrons and the ward managers quite often because of so much admin and other bits they are involved in they are not able to take on the direct responsibility of mentoring a student. But they can be very effective co-mentors and sign-off mentors because they will have the confidence to decide whether the student is fit enough or not fit enough to go on the register...so if they worked as co mentors they don’t have to be with the student all the time (because too busy) but yet they will be hands on from time to time and then they will be ideally placed to be a sign-off mentor.” (TPEF 2)

Influence of the introduction of sign-off mentors

When asked whether they thought that the introduction of sign-off mentorship had influenced willingness to be a mentor, a few participants said that they did not know but most thought that it had had no effect in this respect; some adding that this was probably because staff had not given much, if any, thought as to what sign-off mentorship entailed. In one PEF’s experience, willingness to be a mentor had increased for some staff as they perceived that the introduction of sign-off mentorship had increased the status of the role of mentor. The largest proportion of participants however, responded to the question in terms of willingness to become a sign-off mentor. While one said that some staff definitely wanted to become sign-off mentors, most responses focused on the anxieties that the role had provoked, mainly in response to perceptions of increased accountability but also increased workload. As we saw in Chapter 5, Section 5.6.1, an important component of the role of the PEFs and some of the link lecturers had been in allaying staff anxieties about becoming sign-off mentors.
6.5.2 Changing the organisation of service provision

All participants were asked for their perceptions of how changes in the organisation of service provision were affecting mentorship capacity. Those aspects of change that were having an effect on capacity in relation to placement provision are considered here (12 participants). Changes affecting placement provision included trust mergers and changes to the organisation of service delivery.

Trust mergers

As observed in Chapter 4, Section 4.2, some of the trusts included in the study were in the process of merging with others or were shortly to begin the process of doing so. When a trust linked with one of the HEIs in the study merged with a trust that linked with a different HEI, the door was opened to competition between the two HEIs for placements in the merged trust. This was already a source of concern for some of the HEI participants involved in allocating students to placements. One of the programme directors was anxious that the HEI was not as ‘hard-edged’ as other HEIs and so might lose out in what was already a difficult situation for securing placement allocations. From the perspective of the HEI placement allocations officer, trust mergers meant that much more frequent contact was required with the trust PEFs to manage the allocation of students. On a positive note, however, a trust senior educationalist said that a recent merger had meant that a greater range of services were now available for student placements.

Service reconfiguration, reduction and change of provider

Participants described how placement provision was being affected by a climate of change characterised by re-tendering for service provision, re-configuration of service delivery and, in some instances, service reduction and changes of service provider. Provision was affected in two ways: by the availability of practice settings and by the upheaval caused to staff; a trust senior educationalist put it thus:

“All our wards our reconfiguring with the changes entailed into moving into a new hospital and so some of our areas don’t exist in the same way and there have been changes over the number of people we might have in a particular area.” (TSE5)

And a PEF in relation to community settings:

“The impact of changes in practice areas is really difficult with clinics closing and staff feeling that they can’t have students if they know that their clinic is closing.” (TPEF1)

Loss of provision in settings for care of the elderly emerged as of particular concern. One HEI participant had just been informed by a local healthcare organisation they had reduced the number of their elderly day care centres and those remaining would be opening for less time and so the organisation could no longer offer a placement in care of the elderly. A PEF reported that homes for the elderly with mental health problems were no longer employing mental health nurses and so students could no longer be placed there and overall the number of elderly care beds in the trust was decreasing; currently attempts were being made to try and duplicate this kind of experience in other settings.
Changes in team membership and skillmix were also evident and, as several PEFs reported, presented challenges to those involved in placing students. This PEF focused on ward staff profiles:

“In this climate at present, the profile of wards keeps changing. Teams change. When you’ve got three new wards with brand new teams, they’ve got to learn to work together first. There’s all the hierarchies and egos that go along with that, plus then you’ve got to put the students in. It may not be the best time, so you may reduce their numbers, just see how it goes. So there’s factors like that.” (TPEF6)

While another described the additional work entailed:

“...and we are going through a lot of staff configuration and have a new hospital opening soon.. Wards are not going direct from one to another, so I know that for the next 3-4 months I’ve got to look at reconfigurations of teams, because teams aren’t going as teams. I’m not in the ESR [electronic staff records] circuit so I won’t know where staff are moving to....so it will be a lot of footwork identifying what staff move to what ward, to make sure I have enough mentors to support the placement of students.” (TPEF5)

Changes in skillmix were also affecting the number of experienced staff available to act as mentors. In some cases the ratio of registered to support staff was decreasing, in others experienced staff were being replaced by those more recently qualified and the remaining experienced staff felt unable to support students as well as supporting increased numbers of newly qualified staff. Concerns were also expressed about the possible impact of changes in arrangement for providers; for example some thought that managing placements when services went to private providers might be more difficult and there was uncertainty as to what approach GPs would take to student placements when they took the lead in commissioning.

6.5.3 Changes in educational provision

Several changes in educational provision were identified as affecting capacity for placement provision. One HEI had lost some placements through loss of a contract with a trust to provide pre-registration education and other such losses were considered possible. The move from a single to a dual intake of students per year meant that more detailed planning of student time distribution would be required to avoid overloading placements at some times of the year and not using them at others. Limited physical space in practice settings in the community might be further compromised with the combined effect of the ‘training more health visitors policy’ and the inclusion of community experience in the first year of the pre-registration nurse education programme.

At the time of fieldwork, a new curriculum was being introduced and an HEI senior educationalist considered whether aspects were unrealistic in relation to the practical experience that would actually be available to students. This had led to some redefining of experience – for example what constituted critical care since there was insufficient capacity in what had traditionally been regarded as this specialty. Managing the new curriculum was seen as necessitating a dialogue between the expectations of what students should learn and the areas in which it was possible to obtain the requisite skills.
6.5.4 Factors affecting provision of placements for different branches

When participants were asked whether there were any particular difficulties in finding placements for each of the branches, the main finding to emerge was that paediatric placements were the hardest to secure.

**Paediatric placements**

Difficulties encountered in providing paediatric placements were of four kinds: providing in-patient experience for child branch students; providing community experience for child branch students; providing paediatric experience required by both child and adult branch students; and providing mental health and learning disability experience for child branch students.

The numbers of in-patient paediatric settings were being reduced with the increasing provision of care in the community and the streamlining of in-patient services with closure of some wards and reduction in size of others. Hence finding placements for the child branch cohort could be a challenge:

“Yes, paediatrics is a problem because of the streamlining of the services all the time and therefore, yes, it’s only a small cohort of students but it’s actually getting that enriched experience for them can be challenging really. We have got a wide variety of experience for them but again you’ve got to make sure that you haven’t got all the students together in the place at one time. So although it’s very few, the areas are very few as well.” (TSE2)

The in-patient unit closures also presented difficulties in providing adult branch students with this kind of paediatric experience. The small number of school nurses limited the number of child branch students who could be placed in the community at any one time, although one PEF reported that recently funds had been made available to fund mentorship training for all this group of staff.

Overlap between adult and child branch placements was regarded as particularly challenging in the community; a situation one participant described as nearly pushing the HEI ‘over the edge’ and having to make adjustments to the programme and to the requisite student experience. Participants from both HEIs referred to difficulties in finding mental health and learning disability placements for child branch nurses due to lack of paediatric trained nurses in these settings, although one observed that this would be less of a problem once the ‘due regard’ requirement was lifted.

Difficulties in placing child branch students had an impact on the number of students who could be admitted to the programme and required constant efforts by staff to find placements:

“It’s sometimes difficult to get in where there are already other HEIs. We try just to get one or two in here and there and then little by little over time if they have spaces or there are gaps, they might take more and we might be able to negotiate something alongside the other HEI….that’s why we’ve gone to one intake a year for child just to try and ease the pressure.” (HPD2)

**Placements for other branches**

Placing the adult branch was not reported as presenting problems, other than where this entailed an overlap with child branch students. Participants involved in placing mental health students said that in the main this was not a problem; the only difficulty had been encountered over placements in child and adolescent mental health services as only a few mental health nurses were employed. The
lifting of the ‘due regard’ restrictions would mean however that other staff could act as mentors, although would still require training for this role. Although the project did not explore mentorship capacity for learning disability nursing, four participants whose remit included this branch said that they had encountered difficulties in accessing placements.

6.5.5 Factors affecting the provision of community placements

Responses made by participants (21) about providing placements for students in community settings addressed three issues: changing demand and availability; challenges to mentorship in community settings; and approaches that were being developed. These are considered first in relation to mental health placements and then adult and child together.

Placing mental health branch students in community settings

As with placements generally (6.5.4), participants involved in placing mental health students in the community did not perceive this as being particularly problematic, although in both trusts it was seen as more challenging than in-patient services because of the far smaller number of mentors in post. One PEF said that it was important to develop all community services in the trust as placement areas since so much more client care was provided in these services than hitherto and another described the work they were undertaking in piloting the placement of students in the community during the first year of the course.

Placing adult and child branch students in community settings

Demand and availability: As with the mental health branch, demand for community placements was increasing in the adult and child branch programmes in response to the new curriculum and the increasing provision of care outside the hospital. Several senior educationalists and programme directors from both HEIs expressed concern about whether sufficient capacity was available to meet these demands. They identified the following factors as limiting capacity: the reduction in the number of hospital beds and a concomitant decrease in the number of mentors had not been matched by a corresponding increase of mentors in the community; the number of available mentors in the community would decrease since 40 or 50% of community staff were due to retire in the next five years; and increasing pressure from other groups of students for community experience, for example the recent policy drive to train more health visitors.

Challenges to mentoring in the community: Participants recognised that mentoring in the community presented various challenges for mentors and for those responsible for placing students with them. Much of the care delivered in the community was undertaken by health professionals working alone; this meant less opportunity for staff to discuss concerns they might have about mentorship with colleagues and potentially less opportunity for staff to be up-to-date with more recent approaches to care that the student might have learnt on their pre-registration course. Staffing situations in the community could change very rapidly; a PEF observed that one could have a really good placement with lots of mentors and then it changed overnight with some staff having to go elsewhere:

“...then of course it throws it all into chaos – because the remaining staff have to cover the caseload, look after all the patients, look after all the relatives and you’ve got to look after the student.” (TPEF4)
Participants recognised that many community services were undergoing rapid change and that staff were under such stress that taking on students to support was regarded as too demanding. Some thought however, that in some instances, excuses were offered for not taking students; an example was given of a community team stating that they only had room for one chair and so were only willing to take one student even though there were five mentors in the setting.

**Approaches to increasing community capacity to support students:** Trust and HEI participants described their approaches to increasing community capacity and these included: using the community more for final destination placements so that students might be encouraged to work in the community subsequently and hence increase nursing numbers; a new placement allocation officer focusing on finding new community placements; and looking more broadly at what could be regarded as community experience. One participant offered the view that although there were many reasons why staff in settings that provided care closer to home environments were reluctant to support students such as staffing levels, travel, and complex relationships with GPs, nonetheless they should be willing to take much more responsibility for supporting student learning than they did at present.

**6.5.6 Capacity for specialist placements**

Of the participants (14) who offered a response about the availability of specialist experience, a few said that it presented no problems, mainly because the trust in which they worked or linked with provided the full range of specialities and that hospitals had become much more specialist with the transfer of services to the community. Other participants identified two difficulties that could restrict the amount of specialist experience available to students: bottlenecks over access and availability of staff in specialist areas to be mentors.

**Over demand for certain specialties**

A couple of participants observed that while overall the number of students matched the number of mentors in specialist areas, too many students wanted the same specialty for their elective placement:

“The fact that we say that at the end of the course we can offer them an elective means that they think they can go wherever they like but they can’t because of capacity. They all want to go to A and E or ITU but there isn’t capacity. I’d like to encourage students to be adventurous about their elective.” (HPD5)

**Availability of staff in specialist areas to be mentors**

A more frequently cited problem was the lack of staff in specialist areas available to be mentors. One of the reasons for this was that staff did not always meet the NMC criteria of having mentored two students in the last three years and hence were not eligible to mentor students without taking the course again and, as one HEI senior educationalist observed, no trust would pay them to do the course again. Another reason was reluctance on the part of some specialist areas to support students other than third years, the reluctance of individual clinical nurse specialists to mentor students, and staff already being committed to mentor post-registration students studying for specialist qualifications. Examples were given of successful attachments of students to specialist
nurses when the latter was working in generalist settings and of attachments that proved too difficult to co-ordinate with other demands on the nurse specialist’s time.

6.5.7 Capacity for placements in the independent sector

The final type of placements considered were those based in the independent sector and this included private hospitals and homes – the latter described variously as nursing homes, residential homes and care homes. Of those who commented (15), three HEI participants responded in terms of why they did not use this sector: lack of opportunity, limited independent providers in child health services and lack of mentors among the staff.

Other participants spoke about why the HEI and independent sector staff were keen for student placements in the sector and the kind of support that was required. Participants from both HEIs said that capacity for placing adult branch students in the independent sector was increasing and that they wanted to see it increase further on the grounds that it provided good experience for students. At present, capacity was not being fully used, partly because nursing homes had not wanted to have large numbers of students and some homes had only one or two staff qualified as mentors. In one HEI, staff were increasing the number of nursing home placements in order to find general experience for the first year of an oversubscribed adult branch cohort. Additional mentorship courses were being run in order to get more care homes on stream and this had a snowball effect in that other homes then requested places on the module.

Participants who had experience of linking with independent hospitals said that the staff really enjoyed having students, since it demonstrated that they were contributing to the education of nurses for the NHS and that it was stimulating:

“They have really indicated that they also value students coming into their areas because in the independent sector as a whole, they said you lose touch with what is happening and having students makes you realise what is going on in the NHS and in healthcare generally.” (HSES)

These points about the prestige and stimulation afforded by mentoring students echoed the sources of motivation attributed to independent sector staff for wanting to become mentors (Chapter 5, Section 5.2.3).

Participants from both HEIs reported that placing students in the independent sector was resource intensive for the HEI and particularly so for nursing homes. These were dispersed over a large geographical area each perhaps taking only one or two students and this was costly in terms of travelling times for the link lecturer. The nursing home staff needed a lot of support in getting mentorship off the ground, IT facilities were often inadequate, and staff turnover was high and when a mentor left students had to be withdrawn. However, participants from both HEIs described ways in which they were working to overcome these difficulties and these have been reported elsewhere; for example preparing sign-off mentors (Chapter 5, Section 5.8.2) and in holding forums to support mentors across the sector (Chapter 4, Section 4.5.3). Dedicated HEI and trust staff to support student education in the independent sector had been appointed and more such appointments were advocated if the full potential of this sector for pre-registration nurse education was to be realised.
6.5.8 Key points on factors affecting placement capacity

- Diverse factors affected placement capacity and HEI and trust post-holders were developing and deploying a range of initiatives to mitigate the adverse effect of these.

- Some factors took the form of individual or setting willingness to support students, others resulted from external changes to service delivery and curriculum design.

- The community, the independent sector and specialist services all presented specific challenges for placement provision.

- Branches differed in the ease with which placements could be found with child branch particularly affected and mental health least.

6.6 Sustaining and enhancing placement capacity

Ensuring that placement capacity was sufficient to meet demand was a high priority for HEI and trust staff. Participants’ responses (15) indicated a range of initiatives in place to enhance capacity of existing placements (6.6.1) and avoid placements being removed from the circuit if at all possible (6.6.2). Some participants (12) advocated adopting different approached to the provision of practical experience (6.6.3).

6.6.1 Enhancing capacity of existing placements

Initiatives to enhance the capacity of existing placements included encouraging and enabling staff to become mentors. Pursuing some of the points made in the previous section, particular reference was made to encouraging nursing home staff to undertake the mentorship course and one of the link lecturers for this sector spoke of the need to have marketing and public relation skills to encourage nursing homes to be involved in mentorship. A primary care trust link lecturer thought that many community staff nurses would be good mentors but needed to upgrade their academic skills to be able to get on the course; helping them to do so would enhance mentorship capacity in the community. Regular meetings with trust colleagues (Chapter 4, Section 4.5) provided a forum for discussing which areas should be encouraged to put forward more of their staff for the mentorship course.

Good working relationships between HEI and trust partners were cited as facilitating getting staff onto a mentorship course very quickly in the event of a sudden deficit of mentors. This entailed the trust being able to access a spare place on a course at short notice and the HEI putting on a new course so that recently appointed staff could acquire the mentorship qualification quickly and make good the deficit of mentors. Another approach to enhancing capacity was encouraging specialist areas that had previously only been used for third year students to take students from other years, a task made easier by the NMC recommendation that all placements should be available to all students.

6.6.2 Preserving existing placements

Placements were regularly audited to ensure that the quality of the learning environment met the required standards and could be removed from the placement circuit if these standards were not in evidence; a process discussed further in Chapter 8, Section 8.6.2. Of relevance here, is the effort HEI
...and trust staff expended in avoiding the removal of a placement from the circuit in view of the reduction in placement capacity that this entailed.

In the accounts given, participants spoke about ‘desperately trying to keep placements in’ and that removing one ‘would be a last resort’. The approach adopted was described by an HEI senior educationalist:

“We send the PEFs and the LLs down there, we meet with the sister, the chief nurses or the lead nurse for education might be involved. So we might go in a little bit top heavy but it is often because of poor performing ward managers or clinical managers.” (HSE5)

The importance of not adopting a punitive attitude was stressed by a programme director when referring to an area that had requested having a break from mentoring following a complaint from a student who had also requested a move. The approach taken was to grant the student’s request for a move but then the programme director met with the staff and discussed the complaint as an opportunity for learning; the staff subsequently chose to keep students. Another programme director discussed the challenge that concerns over placement capacity could present in achieving a balance between quality of the learning environment and having enough mentors to match student numbers:

“If I was giving you management speak I would say yes, we closely monitor the placements, but while we do monitor we are bit more, laisse faire about it, because we can’t afford to lose the placement. It’s that sort of paradox of trying to maintain the standards but if you stick rigidly to the standards you lose the placement and then we end up with loads of students without any placement.” (HPD3)

But quality was paramount as this participant went on to say:

“Because of lack of capacity we would try desperately hard to work with the placement area and keep close monitoring on it to make sure it is coming back up. If it’s just not getting there we would take our students off.” (HPD3)

It was also in the interests of clinical areas not to have their status as a suitable learning environment removed; a point made by one PEF in relation to annual updates.

“Placements can be removed if mentors are not up to date. And I said I would remove the students, and in a week everybody was up to date. Nobody wants to have a negative image.”(TPEF2)

6.6.3 New models and approaches to placement provision

Changes in the organisation of health service delivery had led some participants to consider different approaches to the provision of practical experience for students, some of which were in the process of being implemented with others under consideration.

One approach when the existing definition of requisite practical experience restricted the settings available to the point when capacity did not match demand, had been to change the focus and name of a placement to enable a wider spread of settings and people to be involved. Examples included a
primary care trust with insufficient numbers of district nurse and health visitor mentors changing ‘community experience’ to ‘care closer to home experience’ and a hospital trust changing ‘critical care experience’ to ‘acute care experience’. Another approach under consideration was whether placement allocation should be centralised; either across all the health and social care schools in an HEI and/or nursing placements centrally allocated across a strategic health authority. The latter suggestion arose in response to a central allocation system that had recently been adopted for some of the allied health professionals to address difficulties finding placements for these groups.

As we saw in Chapter 5, Section 5.4, when participants were asked whether all nurses should be mentors some felt that a different approach to the current one was required. There were variants on the models proposed but in essence entailed all nurses supporting student learning and a smaller cadre of experienced mentors being developed to support nurses but also to assume responsibility for monitoring and assessing student progress. A similar situation arose over how placement provision should be developed with several participants offering different models to the current one and which to some extent were related to new models of developing nurses as mentors.

Some of the mental health settings had adopted a ‘client attachment’ model in which the student was allocated to a client and then gained the practical experience available at each stage of the client’s care journey with mentoring provided by staff at each of these stages. Observations by participants working with other branches thought that some students might need a more directed approach than client attachment and that the degree of supervision that the model entailed would be difficult to achieve with the numbers of students in the adult branch cohorts.

The other model was known as ‘hub and spoke’ in which a student was based in one setting with a mentor but during the placement period spent time in other related settings. Advocated by the NMC, partly in response to a perceived decrease in capacity for practice settings to host students for the full period of the placement, HEIs and trusts were at different stages of implementing the model at the time of project fieldwork (November and December 2011). A lecturer linking with a primary care trust said that they were using the model; the hub varied but might for example be a health centre in which students gained experience but also spent time in spokes such as a period of time with a district nurse and a period based in a smaller community clinic. However, the student always returned to the hub for periods within the placement although not necessarily always to the same mentor since the mentor might have moved.

In one of the mental health trusts, the PEF said that the hub and spoke model was in operation in some parts of the trust but not others. The link lecturer for the trust described some of the difficulties encountered in trying to get staff to use the model. Using the example of a 12 week ward placement (the hub) with time also spent with community teams (the spokes); she said:

“Despite, every, every attempt it still hasn’t…I don’t think people feel brave enough to do it. I think they’re waiting for somebody to do it and see if it works and then they’ll take it on board. But they’re certainly not there yet.” (HPL 3)

A PEF and a link lecturer in one of the hospital trusts had both given consideration to the ‘hub and spoke’ model. The PEF described how various practice settings could be linked as hub and spokes but the link lecturer was concerned as to how it would work in practice:
“And what they’re getting at there is that they foresee in the future it’s not going to be possible for a student to just sit in a practice area for x number of weeks, that it’s going to be far more hub and spoke and the whole thing is a Practice Learning Experience. Now how a mentor follows that through and assesses, I haven’t got a clue.” (HPL2)

Another PEF described how a ‘hub and spoke’ model might be linked to ‘long arm’ mentoring. Discussions had been held with clinical nurse specialists (CNS) to act as ‘long arm’ mentors – the scheme was based on the CNS mentoring a student for the whole of a year or the whole of the programme, the student gained requisite experience in a range of areas and the mentor to whom they were attached in each of these fed back information on the students’ progress to the ‘long arm’ mentor. The CNSs had seemed keen on the scheme but discussions were at a very exploratory stage over how it would be organised and how much time they would have to devote to their role as ‘long arm’ mentors.

6.6.4 Key points on sustaining and enhancing placement capacity

- HEI and trust staff expended considerable effort in sustaining and enhancing placement capacity to ensure that there are sufficient on the circuit to meet the demand for places.

- Initiatives included: encouraging staff to become mentors, arranging more course places at short notice, and working with trust staff to retain placements that were seen to be failing in some way.

- Such initiatives were facilitated by good working relationships between trust and HEI colleagues.

- Several new models of placement provision were detailed (client attachment, hub and spoke, central allocation) and the importance highlighted of being able to engage staff in accepting new approaches.

6.7 Matching commissioned student numbers with trust capacity to support

Having been asked about various detailed aspects of placement capacity and student allocation, participants were also asked if they thought that the overall number of students matched trusts’ capacity to support them and two perspectives emerged from the diversity of responses made (29). There was the macro level of decision-making about the number of student places to be commissioned (6.7.1). Then there was the question of how the decision looked on the ground as HEI and trust personnel sought to place each student (6.7.2).

6.7.1 Deciding on the number of student places to commission

Most of the HEI (4/5) and trust senior educationalists (6/7) from both groups (A and B) discussed the process of commissioning student numbers. Some expressed uncertainty about how the commission was worked out while others described a process that they felt omitted the views of the people best placed to know how many students a trust could actually support. They perceived the process as follows: the strategic health authority worked out the numbers with the trusts but discussions to this end appeared not to involve senior nursing personnel; instead it was thought that discussions were most likely held with personnel in a human resources or workforce department. This number of students was then presented to the HEI as the number they had to educate and then
the HEI informed their nursing colleagues in the trusts with which they linked of the number of students that would need to be placed.

The perceived problem hinged on the HEI being told by the SHA that the numbers had been agreed with the trust but the people in the trust with a remit to provide nursing services for patient care and student education had not, in fact, been involved in the decision. From an HEI perspective, participants said that they were on the receiving end of a number rather than being involved in a discussion about what was possible. From a trust perspective, the number of students they were asked to support had been worked out by trust staff who were non-clinical and perhaps unaware of the way in which capacity to support students was changing all the times as services were reconfigured. In the view of a trust senior educationalist the result could be a clash of view over ‘what we can actually take and what they have been told they have to train’.

Other observations about the commissioning process made by the HEI senior educationalists included: difficulty of planning against a background of volatile trust capacity and a very short time between receiving the commission and having to confirm placement capacity. Reference was also made to the likelihood of reductions in the number of student places commissioned in light of changing policies over workforce numbers and service capacity and the implications that this might have for the number and size of nursing schools that might eventually be required.

6.7.2 How do commissioned numbers work out in practice?

So having received a number of students to be educated how did finding the requisite kind of placements and having the required numbers of mentors in place work out in practice? The perspectives of the HEI senior educationalists and programme directors are considered first followed by the perspectives of those responsible for placing students in each trust – the senior educationalist and the PEF for each trust, together with the HEI link lecturer.

HEI senior educationalists and programme directors: views on trust capacity for placing commissioned numbers of students.

Most of the HEI senior educationalists (4/5) and programme directors (5/6) made observations on matching commissioned numbers to trust capacity. Responses focused on reasons for perceived mismatches between student numbers and trust capacity and the number of nurses and mentors in post.

In some participants’ experience, numbers matched capacity in the hospital trusts but that there were difficulties in the community. ‘Bunching’ of students was described as exacerbating an overall mismatch; for example when some students progressed at a slower rate than the rest of the set or returned after maternity leave – in both instances joining another set already at capacity.

A programme director who found that student numbers did not match capacity focused on the dissonant perspectives of people at different levels in the HEI and trust hierarchies:

“I think there’s a root to this problem that is further back, in that the clinicians and the PEFs are dealing on one level with student numbers, but the people above me and the people above them are negotiating a commission at a different level. So I end up negotiating how many people per ward or facility, whereas they’re bartering on numbers in terms of finance really. Inevitably the
clinical side at a higher level want more students because they’re worth lots of money, but the people at the ground level want less because they’re a huge workload.” (HPD4)

While another thought that the end result on the ground meant that there must be a missing link somewhere in the process:

“I think the main change needs to come from education leads in trusts. This is where it all becomes a grey area because what we’re contracted to take from x [the SHA] doesn’t seem to filter down to the placement areas. When you go back and say ‘Actually you’ve contracted these students’, the answer you get from the ward managers or modern matrons is ‘Actually we didn’t ask for these numbers’. It seems to go to strategic level and nobody seems to come up to that mark. So we’re saying ‘You have contracted for these.’ But they’re saying ‘Well we don’t want them’, I don’t know where the block seems to come. I think there’s a lot of misinformation out there. There is that bit where what we get is a contract, but what actually transpires in the wards there is a big missing link there.” (HPD3)

A mismatch between student numbers and placement capacity was sometimes resolved through negotiation as Section 6.3 has shown. But imbalances could be difficult to resolve if there was simply not enough placement capacity and while it was argued that trusts had an obligation to place the numbers of students that had been commissioned, care had to be taken over mentors’ workloads and students’ experiences:

“We don’t want to load mentors up with too many students and we don’t want to put our students anywhere near a clinical situation where they feel unsafe and where they will be unsafe.” (HSE4)

The view was advanced however, that capacity to support students should be sufficient given the numbers who had attended the HEI mentorship modules.

“The number of mentorship modules we run every year, you’d think there’d be more than enough mentors out there because it runs so many times.” (HPD2).

Another thought that the capacity problem must be due to some mentors not having students allocated to them given that the HEI was training between six and eight hundred mentors every year, while a third perspective was that the problem lay with the traditional structure of the placement, not the number of mentors, given the vast numbers of nurses employed in some areas. An HEI senior educationalist thought that the monitoring of mentorship capacity had ‘fallen between the cracks’ and that it needed to be addressed at higher levels of both types of organisation, preferably based on a mapping of the minimum and maximum capacity of each placement area.

At trust level: views on trust capacity for placing commissioned numbers of students

Turning now to experience at trust level of the match or otherwise between student numbers and placement capacity, the views of participants involved with primary care trusts, hospital trusts and mental health trusts are considered separately given differences that have emerged between them previously (Section 6.3).
Student numbers matching capacity in primary care trusts: The two primary care trusts had both encountered problems over the extent to which student numbers matched placement capacity. In one, a large mismatch had been resolved through the negotiation of new placements and current problems of a temporary shortage of staff were resolved through doubling up students:

“There are times when we have had to double up students...But then we know we would put them with an informed, safe pair of hands, rather than willy nilly, so it’s responsible placing, is how I would call it.” (TSE1)

The other primary care trust had been struggling with a capacity problem for several years and which occasioned comment by the PEF, the trust senior educationalist and one of the HEI senior educationalists. Students at the HEI were allocated to a learning community of practice and the number allocated to each depended on the size of the largest hospital based in the geographical area covered by the learning community. This primary care trust was in the learning community with the largest hospital and hence which had the largest number of students (60% of the total intake). However, the placement capacity in this primary care trust was the same as those in the primary care trusts in the other learning communities of practice but which each had a smaller proportion of students to place.

The outcome of this situation was that the PEF was often faced with having to place more students than for which the trust had capacity. Hence strategies were adopted which were not necessary in the other primary care trusts; such as placing adult branch students with health visitors as there were not enough district nurses and entitling the placement ‘care nearer to home’ rather than ‘community’. Various solutions had been proposed to resolve this dilemma but none thus far had proved acceptable to all parties.

Student numbers matching capacity in hospital trusts: As with the primary care trusts, the circumstances of each of the three hospital trusts differed in some respects.

Senior educationalists in the two trusts that linked with the same HEI as the primary care trust that had to place a high proportion of the student intake, also referred to the impact of allocations based on the size of the largest hospital. The one based in the trust with the largest hospital and hence the largest proportion of the HEI student intake thought that the allocations needed evening out between the trusts. The PEF described various difficulties in placing all the students and felt that much of the problem was created by the commissioning process described earlier. And the senior educationalist, observing that their placements were ‘worked to the maximum’ said that they had always been flexible with the HEI and hence there was an expectation that they could always squeeze in more students:

“Because you are a larger organisation, everybody thinks you can find nooks and crannies to put people into.” (TSE5)

The senior educationalist for the other trust, which was part of a different learning community of practice, said that their allocation of students was based on what the community services in the trust could accommodate. As a rule they managed to place all the students allocated to the trust and planned ahead when they knew a peak of students was imminent. Both the link lecturer and
the PEF for this trust described the juggling that was needed to place students and stressed the importance of the good working relationships between their two organizations. The PEF focused on the patient perspective in these negotiations:

“I think there is something about definitely being consulted about numbers and knowing that you are not...because I so think yes, you want to say yes to your partners but if you pack them in too high the quality goes down. And then if there is a review or a visit or something goes horribly wrong, there could be a patient at the end of it. For me, you’ve got to think about the quality and safety for the students and for the patients, but I think for the patients mainly.” (TPEF6)

Responses of the three participants involved with placing students in the third hospital trust indicated that student numbers matched capacity. The senior educationalist said that everyone got together when a problem occurred to identify how best to find a resolution, although it is of note that these negotiations were reported by the link lecturer as being somewhat challenging on occasions.

**Student numbers matching capacity in mental health trusts**: Participants in both the mental health trusts reported that student numbers did match capacity and this corresponds with earlier findings that these trusts were the least likely to have problems in finding placements. In achieving the match of numbers with placements, one of the PEFs attributed this partly to people’s willingness to be flexible about managing capacity (micro-mapping as described in Section 6.3.2) while a trust senior educationalist was one of those who had observed that capacity should not be a problem given the number of places that they had commissioned on the mentorship course.

6.7.3 Key points on student numbers matching placement capacity:

- The commissioning process was perceived by some as creating difficulties from the outset over the source of information upon which decisions about the number of places was based.

- Most senior HEI personnel involved with adult and child branch programmes perceived problems with matching their student numbers to trust capacity.

- Student numbers were reported as matching capacity in mental health trusts. In other trusts, participants reported that they were eventually able to place the allocated numbers albeit that this often occasioned considerable difficulty and time to resolve.

- Looking ahead, participants’ recommendations included: commissioning based on realistic assessment of capacity, better monitoring of capacity at higher levels of both organisations, and, in some respects, a more effective approach to use of resources that were available.

6.8 Overview of findings on placement provision and student allocation

This chapter has shown that finding and sustaining placements and deciding how to allocate students to settings and mentors is a complex affair, taking place in a climate of constant organisational change and dependent upon good working relationships and ongoing negotiations at all levels.

Ensuring that throughout their course each student was placed with a mentor in a practice setting that contributed to the overall requisite practical component of their education, entailed a range of
processes: staff always being on the look out for new placements; auditing their suitability as learning environments; striving to retain existing placements when concerns arose over quality; planning the allocation of cohorts of students; accessing information to inform decisions about how many students could be supported; encouraging people to be mentors; deciding which student should be allocated to which mentor and allaying anxieties about mentoring students who were qualifying through a different route. The crucial importance of these processes, in particular those concerned with enhancing and increasing placement capacity, have been reported in previous studies (e.g, Hutchings et al, 2005, Magnusson et al, 2007).

However, achieving each of these processes was not necessarily a straightforward matter. Several of the processes were affected by organisational change such as reconfiguring services, trust mergers, and changing skillmix. Sometimes these changes were a hindrance, for example when wards moved and team profiles changed with the effect that staff felt unable to support students until the situation was more settled. Other organisational changes had a facilitative effect, such as the development of new services that could be used as placements.

Many of the processes required a series of negotiations between personnel at all levels of both organisations before a successful outcome could be achieved and throughout the account it has been clear that the willingness of staff to be flexible has been essential in this respect. Good working relationships and a sense of partnership were the key to successful negotiations and flexible approaches to problems. Local knowledge of the nature of practice areas, of staff circumstances and students’ needs were seen to be essential in informing decisions about the number of students that could be supported and the kind of mentor who might best be able to support particular students. And it was people based in practice (the PEFs) or having close links with practice (the HEI link lecturers), who provided this locally based information.

There were some marked differences between the different branches over the ease of being able to place students generally and in the community in particular, with paediatric placements appearing to be the hardest to access and mental health the least difficult. The use of the independent sector in affording students with practical experience was growing and while this required much support from the HEI staff, it was seen as a positive move from both the perspective of the sector itself and for student nurse education.

Areas of concern arose for some participants over: the robustness of the process of the commissioning student numbers; the restrictions preventing some groups of very experienced staff from being mentors; the occasional lack of willingness on the part of service staff to be flexible about the numbers of students they were willing to support; and balancing the ability to maintain placements while not compromising on quality of the learning experience for students. In the main, however, participants described the processes of finding placements and allocating students as being achieved. The findings presented demonstrate the resource intensive nature of this achievement in terms of the diverse personnel involved and the time that was required in negotiations, acquiring information, building and sustaining good working relationships; and maintaining quality of student nurse education.
Chapter 7: Mentorship capacity: educating learner mentors to facilitate learning and assess competence

As the previous two chapters have demonstrated, capacity to sustain delivery of student nurse mentorship requires sufficient numbers of mentors and sign-off mentors in practice settings that are suitable learning environments for students. A crucial aspect of capacity to provide high quality mentorship is the extent to which these mentors and sign-off mentors are appropriately prepared for their roles in facilitating student learning and assessing their competence. This is the focus of the current chapter. Those attending the mentorship course are referred to throughout the chapter as learner mentors and those mentors taking sign-off mentor preparation as trainee sign-off mentors.

The first two sections provide contextual information about the mentorship course: its structure, staffing and course membership profile (Section 7.1) and its development, content and methods employed for assessing learner mentors (Section 7.2). The following three sections each focus on an aspect of delivering the course: face to face and on-line formats (Section 7.3); support for learner mentors from higher education and trust personnel during the course (Section 7.4); and the various challenges encountered in course delivery (Section 7.5). In Section 7.6, the focus turns to perceptions of the adequacy of the course in preparing mentors for their role, while Section 7.7 concentrates on the key post-holders in this respect – the mentorship programme leaders and course teachers. Sign-off mentor preparation is considered in Section 7.8. The final section (7.9) draws together the key findings.

7.1 The mentorship course: staff involvement, structure, and course membership

Participants’ involvement in the course are described first (7.1.1) followed by the structure and format of the course (7.1.2) and course membership (7.1.3).

7.1.1 Participants involvement in the mentorship course

The HEIs differed to some extent in the format and organisation of the mentorship courses that they offered to staff in their healthcare provider partners and this was reflected in the study participants’ involvement in, and knowledge of, the course. At HEI-1, the mentorship modules were organised and taught by the mentorship programme leader, with members of the lecturing staff participating in the teaching; all bar two of those interviewed had current or recent experience of teaching on the course and most had been involved in its development. All the HEI-1 participants were conversant with details of course content and mode of delivery.

At HEI-2, mentorship modules were offered under the auspices of an education development unit and, as with HEI-1, were organised and taught by the mentorship programme leader. Programme directors for the BSc and Masters’ degree were involved in the organisation and content development of mentorship modules included in their respective courses. These mentorship courses were taught by a team appointed specifically to work in the unit, not all of whom had a nursing background, and two of whom was interviewed. Two other project participants had had experience of teaching on the course at a time when it had been organised differently. The somewhat separate nature of the provision of the HEI-2 course was reflected in that most of the HEI-2 participants were less conversant with the format and content of the course than their HEI-1 counterparts.
Trust participants’ involvement in the taught component of the course in both Groups A and B, took the form of contributing to the development of the content of the module. They did not undertake any of the teaching with one exception; one of the Group A trusts also offered an in-house course taught partly by staff from the HEI and partly by trust staff. In Group B, the HEI-2 team had asked PEFs if they would like to contribute to sessions in the future so that course content might best reflect revisions currently being developed. Trust staff were, however involved in the preparation of sign-off mentors (Section 7.8).

7.1.2 Structure and format of the course
At HEI-1, a blended learning course (part face to face sessions and part on-line sessions) and an all on-line distance learning course were offered. Most of the trust staff taking the course chose the blended learning course which was offered at a level 5 or a level 6 and was worth 20 credits. Previously the HEI had offered a solely face to face course and a solely on-line version but following a recent validation visit by the NMC, the format had been changed to a blended learning version with three face to face days and three e-learning days; a decision made in conjunction with trust partners. The blended learning course was spread over 15 weeks with study days at two week intervals and alternating between face to face and e-learning days, with activities for the latter set up at the former. The e-learning days could be undertaken when convenient for the learner mentors. The mentorship programme leader however, expressed concern that trust pressures over workloads might have meant that study leave had to be foregone and the course work then had to be undertaken in the learners’ own time.

At HEI-2, the mentorship modules offered by the education unit included one at masters’ level for students on the masters’ degree in nursing and one at level 5 primarily for healthcare provider staff and also those on the BSc in Nursing. Both courses were worth 15 credits and both were available in a face to face version (80% face to face and 20% on-line) and, more recently, in a sole on-line version. Learners on the masters’ module and the level 5 course were taught in the same class with additional seminar lecture content provided for the masters’ course learners. The course comprised five study days taught fortnightly over ten weeks. The timing of the study days had recently been changed from 9:00 until 14:00 to 10:00 until 15:30; the mentorship programme leader explained that this was in order to straddle the two trust shifts as previously learners had been expected to return to work and do an afternoon shift. The new timings meant that this was not possible and so learners were able to spend time before and after the session using the library and HEI-based electronic resources. A trust senior educationalist said that they had recently requested a blended learning module and discussions were in hand on the matter.

7.1.3 Course choice and membership
The courses offered by both HEIs were open to staff from all the healthcare providers with which the HEI linked and to all branches of nursing and from midwifery. This enabled learners to see the common issues and problems that mentorship posed and to learn from the experiences of those working in settings different from their own.

There was some indication however, that mental health trusts also wanted branch specific courses. Thus HEI-1 ran an on-site course for a mental health trust unable to make sufficient time available for off-site attendance for the numbers of staff they wanted to send at the same time. The senior
educationalist for a mental health trust in the project would have preferred an HEI-based course solely for mental health staff on grounds that it would be easier to commission within the trust. However other participants with a link to mental health practice thought that a branch mix was better for mental health staff when learning about mentorship:

“Mentorship is mentorship is mentorship, the process is the same, you don’t need someone who is mental health trained just teaching mental health. The process they’re all doing is the same.”

(HPL3)

Learner mentors arrived on the course with very different backgrounds in relation to their own nurse education and the teaching and learning styles with which they were familiar. This posed considerable challenges for those teaching the course (Section 7.5.2).

Participants at both HEIs said that, in the main, learners could opt for the format they preferred. At HEI-1, far more chose the blended learning rather than the on-line version and at HEI-2 most learners took the face to face version as the on-line course had only fairly recently been introduced. Reasons for opting for the on-line version are discussed in Section 7.3.2.

7.2 The mentorship course: development, content and assessment

This second background section focuses on course development (7.2.1); course content and aims (7.2.2), and the means by which learner mentors were assessed (7.2.3).

7.2.1 Developing the course

In Group A, the mentorship course was developed by a team including the programme leader, the senior educationalist with a practice-based remit and those members of the HEI staff currently involved in teaching along with representatives from the trusts with which it linked. In Group B, the mentorship programme leader described how when appointed she encouraged the team of specialist mentor teachers in post to contribute their diverse insights into course development along with input from trust representatives. In both Groups, representatives of trusts were involved in discussions about the ongoing development of the course at one or more of the joint HEI/trust meetings (Chapter 4, Section 4.5). From the trust side, it was most likely the PEF that was involved, both in developing the content of the module and participating in discussions about its ongoing progress; the latter included feedback on the quality of course preparation as indicated by perceptions of mentorship delivery in their practice area. Participants from both types of organisation stressed the importance of this joint approach.

All participants concurred with the view that the content of the course was developed on the basis of the eight NMC domains; namely establishing effective working relationships; facilitation of learning; assessment and accountability; evaluation of learning; creating an environment for learning; context of practice; evidence-based practice; and leadership. The content of the on-line courses were the same as the blended learning and the sole face to face versions. Most participants said that the aim was to give the domains equal weighting, although two participants thought that this was difficult to achieve as there was considerable overlap between three of the domains.

The course was subject to validation by both the HEI and the NMC and comments made by HEI senior educationalists indicated the kinds of issues that might be raised: one observed that their HEI
validation panel had difficulty in understanding that the learning outcome of the course was to meet a set of learning outcomes (i.e. the 8 domains) while another said that the course had recently been structured more tightly around the domains following comments made by a visiting NMC validation panel.

### 7.2.2 Course content and flexibility

While details varied, participants from both HEIs described how the course was structured around two key aspects of the mentor’s role – facilitating learning and assessing competence. At HEI-1, the blended learning course allocated a face to face day and an e-learning day to each of the three themes around which the course was structured: planning learning, facilitating learning, and assessment of learning. Similarly at HEI-2, the first of the five study days on the sole face to face course provided an introduction to the subject, the second focused on creating a learning environment and thinking about learning theories, and the other three were devoted to assessment, evaluation and leadership respectively. A mix of strategies were employed on the face to face study days at both HEIs and included: group work, individual work, role play, lectures and discussions; and drew on a range of multi-media materials such as story boards and video clips.

The course placed considerable emphasis on assessment; both enabling learner mentors to assess that learning had taken place and to make an assessment as to whether a student was competent in relation to particular skills or knowledge. Aspects of the course focusing on assessment included: providing constructive feedback; understanding principles of assessment such as validity and reliability; understanding the process of making an assessment and not just how to complete the required documentation; how to recognise when a student’s personal problems or perhaps a disability may be affecting their performance; and on the professional accountability and responsibility entailed in stating that a student is competent. Scenarios of good and poor examples of mentors assessing students were used to illustrate these points and course exercises included learning how to develop a critical analysis of the encounter.

Course content was fairly tightly prescribed and this was evident in responses made by participants when asked how much flexibility they had in its delivery. Those with recent or current experience of teaching the course said that there was little flexibility over course content but that other aspects of the course were more flexible.

The rationale for lack of flexibility offered by HEI-1 participants, with some 7 to 800 students coming through the course each year and 15 lecturers on the teaching team, having common content and order of topics was essential to ensure consistency of coverage. The mentorship programme leader provided a guide for the teachers on what needed to be covered each day and the slides and videos to be used had all been planned and prepared in advance; she and team members cited these resources as an example of good practice in the education of mentors. Examples at HEI-1 of the kind of flexibility that course teachers were able to deploy included: spending more time on topics for which learners expressed the need for more guidance and less on those that they grasped quickly; going back over particularly important topics again at a later stage in the course such as all the NMC documentation and factors contributing to why mentors may ‘fail to fail’ students; and adopting methods perceived as most appropriate for the learning objectives that they had set for their group on one of the study days.
At HEI-2, the modules were described as not being as prescriptive as hitherto and that the programme leader afforded the team flexibility in how they taught the course. While, as before, the NMC standards had to be covered and the same learning outcomes achieved, this more flexible approach had enabled different methods and resources to be developed which the team shared. For a recently appointed member of the teaching team, these jointly developed resources were much appreciated.

Concurrently with course study days, learner mentors continued to work in their own practice settings where they undertook the practical component of the course; namely working with a student in their practice area under the supervision of a qualified mentor, often referred to as a mentor buddy. All the PEFs and most of the TSEs described the mentor buddy system as did most of the HEI participants involved in the course. Various people qualified as mentors were identified as acting as mentor buddies and these included: mentors, key mentors and sign-off mentors; and PEFs, clinical leads, community practice teachers and managers of practice settings. Working with a student in practice under the supervision of a qualified mentor enabled the learner mentor to translate the course content into practice and also bring back examples of experiences and problems encountered for discussion at the next study day. As one of the HEI participants put it:

“At the end of the day you learn by doing it.” (HSE1)

The course requirements specified that the mentor buddy had to sign a form to verify that on three occasions, the learner mentor had assessed a student or witnessed a student being assessed.

The course encouraged learner mentors to consider various practical aspects of delivering mentorship in practice and examples included: changes that they might need to make to ensure that their students were spending 40% of their time being supervised; booking a room in which to provide feedback rather than trying to do this in a busy office; having a welcome pack to give their students on arrival; and setting aside time to spend with the student at the start of the placement. While the course was designed to provide a strong theoretical underpinning to the delivery of mentorship, it was practice focused throughout:

“So I think yes it is very much focused on what they’re actually going to do when they become mentors.” (HPL5)

7.2.3 Assessing the learner mentor

The written assignments that formed the basis of assessing the learner mentors reflected this dual theoretical/practical perspective with specific details varying between the two HEIs. In one HEI, assessment was through two written assignments. The first was a formative piece about mentorship which the group of learners peer assessed as a means of gaining further ideas on the subject and learning about the principles of giving feedback. This piece of written work provided the module teacher with an opportunity to identify those who might be struggling with writing and hence to offer assistance in this respect. The second assignment comprised a 3000 word essay in which the learner mentors had to reflect on their experiences of supporting the student, assessing them and giving them feedback, followed by a general reflection on the role of the mentor and planning for their own future in this role.
In the other HEI, three assignments were described. The first was a formative assignment in which the learner mentors had to identify one action that could improve the support of students in their own practice area; the course tutor provided feedback before submission and, as in the other HEI, this provided a first opportunity to identify those who might be struggling with constructing an academic piece of work (a point expanded further in Section 7.5.2). This was followed later in the course by a summative assignment in which the learner mentor had to develop a learning outcome for a student in their area, identify all the resources that they would need to bring to bear on achieving this, and then make an assessment of whether learning had taken place. A second summative assignment focused on assessment of competence; this took the form of a 1500 word essay in which the learner mentor had to write a critical analysis of a scenario depicting an assessment focusing on key issues such as the validity, reliability, fairness, feasibility, and discriminatory power of the assessment. As with the first formative assignment, feedback was given on drafts of the summative assignments before submission.

In both HEIs, the overall assessment of the learner mentor was made on the basis of the written assignments together with the written report and signed verification made by the learner mentor’s supervising mentor. Those involved in teaching the course spoke about the importance of ‘embedding the standards’ into learner mentors at the start of the course and how they constantly referred to the standards throughout the course and expected the learners to use these benchmarks in all their assignments. The centrality of the standards was also evident in observations about the practical component of the course. One of the PEFs thought that supervising mentors found translating the domains into how best to support a learner mentor challenging since they themselves were still trying to get to grips with the domains which had only relatively recently been specified by the NMC. In order to address this, the mentorship programme leader in HEI-2 and one of the PEFs in a linked trust described how the HEI team and the PEFs had developed a more structured competency document for the supervising mentor to follow and which monitored the learner mentor against the standards.

7.2.4 Key points about the mentorship course
This section summarises the main points about the mentorship course covered in these two background sections (7.1 and 7.2).

- Two models of course provision were included in the study: in one HEI the course was taught by a team of lecturers who also held other teaching responsibilities in the faculty as well as linking with practice; in the other HEI, the course was taught by a team appointed to a separate education unit within the faculty.

- Trust personnel did not teach on the course but were involved in the development of its content and monitoring of its progress. A range of teaching materials had been developed by the HEI teams with input from trust colleagues.

- Both HEIs ran a sole on-line course, one had a sole face to face course while the other had a blended learning course.

- Course membership was drawn from all branches of nursing and from midwifery.
Course study days were held at regular intervals, content was developed on the basis of the 8 NMC domains and a range of teaching and learning methods were deployed.

Between study days, learner mentors continued to work in their practice setting with mentorship activities supervised by a ‘mentor buddy’ who signed a verification document of what the learner mentor had achieved.

Assessment of the course was by means of a series of written assignments.

7.3 Delivering the course: using face to face versus on-line modes

Having considered key aspects of course structure, content and provision, the next three sections focus on aspects of its delivery. This section considers participants’ perceptions of the advantages and disadvantages for learner mentors and course teachers of delivering the course via a face to face or an on-line format.

The situation in the two groups differed in that HEI-1 offered a sole on-line module and a blended learning module whereas HEI-2 offered a sole on-line and a primarily face to face module (Section 7.1.2). The face to face sessions in both HEIs were also supported by on-line materials. Here we consider some of the capacity issues raised by the two modes of provision: the rationale given for moving to online provision (7.3.1); learners’ preferences for one option rather than the other (7.3.2); accessing on-line provision, skills required and reliability (7.3.3) and benefits of face to face provision for aspects of the course (7.3.4). In both HEIs, participants involved in the course had experience of teaching mentorship in face to face and on-line formats and those in trusts had knowledge of both through feedback from staff who had attended the course.

7.3.1 Rationale for increasing on-line course provision

Group A participants said that following the last validation of the mentorship module, the format was changed from face to face to blended learning. The decision to do so was the result of discussions between the HEI and their partner trusts and based on feedback from learner mentors and employers and on a consideration of whether all aspects of the course needed to be classroom-based. The main rationale for this change according to the HEI participants, was that the trust found it too costly to have staff off-site for all the requisite study days; a point that was endorsed by the trust participants. One of the PEFs observed that the move to blended learning had made it much more manageable to run the services around staff attending the course and another added:

“Because to reduce time and to make it easier for people to attend, they’ve arranged it so that there’s a couple of sessions at the university and there’s bits and pieces that they learn online.”

(TPEF1)

Although most participants said that the move had been largely driven by their partner trusts, the mentorship programme leader observed that the university was also moving toward more on-line course provision on grounds of saving resources in the form of lecturing staff time.

Among Group B participants there was also recognition that there would likely be a move towards more on-line provision of the mentorship module. A trust senior educationalist had already requested that the HEI provide a blended learning module, another said that several other courses
commissioned by the trust were already being provided in an on-line format. Like their Group A counterparts, the Group B HEI and trust participants reported that the main driver was a reduction in costs to the trusts particularly in view of increasing scarcity of resources. The on-line course already provided by the HEI had been developed for a trust that had had to have a rapid increase in the number of mentors but without releasing them for off-site study days.

7.3.2 Learners’ preferences and motivation for different formats of provision

Reasons for wanting an all on-line course: Participants at both HEIs identified groups of learners who opted for the all on-line module and these included: those who were funding themselves as the course was cheaper than the options involving face to face sessions; those whose personal circumstances made an on-line course easier to fit around their family commitments; those who preferred studying at flexible rather than prescribed times; and those who wanted a place quickly as there were shorter waiting lists for the on-line compared with the other courses. At both HEIs, fewer learners opted for the on-line course than the blended or all face to face versions and one participant observed that the choice was usually made on pragmatic grounds not because the online option was ‘a great way to learn.’

Evaluations of blended learning courses: Two points about course formats emerged from student evaluations: firstly that most would prefer a greater proportion of the course to be offered in a face to face format, and second that there was often a split between those who had not liked the e-learning component at all and those who had not done so at first but had grown to enjoy it as the course progressed and their confidence increased.

Giving staff a choice: Several trust participants (both senior educationalists and PEFs) stressed the importance of offering staff the choice of attending a blended learning or an all on-line course on the grounds that they would do better with the format with which they felt most comfortable.

Motivation required: A cautionary note was sounded by participants about the choice of the all on-line course in that they perceived it as requiring more motivation and a more disciplined approach to study than the face to face version and that learner mentors did not always recognise this beforehand. In particular, the face to face course had more clearly delineated milestones than the on-line course and these helped to keep learners focused.

Getting study leave to study on-line: Participants from both HEIs expressed concern that learner mentors from some trusts were given study days for the face to face days but not the on-line days. One course leader said that the HEI was often in discussion with such trusts reminding them that the NMC position was that these were protected days. Concern about protecting time was shared by some of the trust participants; for example a senior educationalist who had asked the HEI if a blended learning course could be provided went on to say:

“But then you also have to think about the blended learning approach because if it’s done face to face, staff are obviously released from the area to do that. If it’s e-learning, are staff actually given the time to sit in a quiet place to undertake it, rather than them doing it at the end of a shift or something? You have to take all these sorts of things into consideration.” (TSE5)
An HEI participant who taught on both the on-line and the face to face course regarded the former as much more challenging for the learner if the trust was not providing study leave, observing that it would be preferable if the on-line course learner had half a day a week protected time.

7.3.3 On-line provision: IT skills required, reliability and perceptions of cost

**IT skills required to study course on-line**

The on-line course and on-line study days in the blended learning course required a certain degree of proficiency in IT skills and HEI and trust participants made several observations about the capacity of learner mentors in this respect. These included: huge variation in the IT skills of members of the same course; the view that younger staff were often more competent with IT than their older colleagues; familiarity of the younger members with email and social media did not always translate into IT competency, and learners sometimes overestimated the level of their IT skills and then found that they were struggling with the on-line work:

“So I think we sometimes tend to forget that our existing staff are not going to be au fait and will not be happy with just total on-line delivery, you do have to have a mixture. And I think we do make an assumption sometimes that we’ll do it all on-line and you’re not actually addressing the needs of those individuals.” (HPL5)

There was an acceptance however that the culture was changing and that all staff would have to become more familiar with IT:

“I believe in blended learning because people can’t always travel and spend the whole day and the service can’t free you – it’s all a mix for the present day ways of working and if we don’t use the technology, we’ll be left behind.” (TSE1)

On the other hand, recognition was needed of the support that learner mentors might require in gaining such familiarity either before starting the course or during it from the teacher and other course members.

**Perceptions of relative costs of the two modes of provision**

While all participants recognised that there was a move towards greater on-line provision and that this was less costly for trusts, the perception that it was also less costly for higher education was contested. Those in both HEIs with experience of on-line courses spoke about the resources that it entailed.

Firstly, there were the costs of the system:

“My other huge concern is that it’s perceived as cheap and it isn’t. It’s more expensive to set up and needs much more back up – technical back up.” (HPD6)

Secondly, it required as many hours of staff time as face to face sessions:

“I think it’s a myth that it’s less work for the tutor because I think responding to peoples’ independent queries and trying to manage threads of discussion and trying to keep people motivated – you end up being on-line an awful lot – chivvying people along, managing discussions, helping people move forward. The cost to the trust is lower because of not having to
release staff. But the burden on the individual teacher would be greater. With face to face time for preparation is defined but with on-line you could be logging on every day.” (MPT1)

**Availability and reliability**

Some of the trust participants raised concerns about the availability and reliability of on-line course provision. Thus one of the PEs said that there was an assumption that everyone had a computer at home and that for those who did not, combined with the limited numbers of computers at work, undertaking the on-line components of the course could be very difficult. Others recounted instances when the on-line course system could not be accessed or when it shut down during a course session.

7.3.4 Face to face sessions: perceived benefits for aspects of the course

HEI and trust participants regarded face to face sessions as having several advantages for course members compared with on-line provision. Face to face sessions were seen as especially valuable for people who had not undertaken any academic study for a long time as the teacher was able to give them support in this respect during the course. Standard of English and extensiveness of vocabulary were perceived as relevant to willingness to participate in discussions:

“I feel that sometimes, it maybe a workshop or a group discussion, may have more benefits than just discussing some of the topics on blackboard because you feel your English is not of a certain standard or you feel that your vocabulary isn’t at a certain level, you may not be as willing to discuss these issues within a blackboard setting.” (TSE2)

Face to face sessions provided opportunities for course members to exchange ideas and information with people from other branches and to share recent experiences of events in practice related to mentoring whereas with the on-line format ‘you haven’t got anybody to have that immediate conversation with’. Course members were able to hear differing views from their own about scenarios of student assessment and then jointly consider different approaches. Course teachers had the opportunity to listen to problems encountered in practice and then perhaps suggest differing ways of how these might be tackled. Helping people to generalise from anecdotes was easier in face to face than on-line sessions. The nature of discussion about these topics differed in quality; a PEF summed this up thus:

“e-learning will give you the theory but not the richness of discussion. Most people once they are qualified they are committed to learn by themselves but they want to know the experience of others in terms of mentoring, reading and actually having a discussion. So a blended approach is more effective than just on-line.”(TPEF2)

Experience of supporting course members on-line led HEI participants to conclude that, although they tried to create an on-line learning community, the learners missed out on group working and discussions, and that discussions held on-line tended to be stilted with each person putting their point of view across, without reading those of others or relating their comments to those contributed previously. One of them observed:

“I think on-line teaching at its best is a support for face to face teaching but I can’t see it replacing face to face.” (HPD5)
7.3.5 Key points on modes of course delivery

- In keeping with general moves towards increased provision of on-line learning, both HEIs had increased the proportion of their mentorship course portfolio offered in on-line formats.
- The main driver for increased on-line provision was perceived to be decreased costs for trusts as staff did not have to be released for off-site attendance.
- Various reasons were offered as to why some staff opted for the on-line option, support was often needed to support staff with inadequate IT skills to manage on-line learning.
- Concern existed about lack of study leave for learner mentors for on-line sessions in blended courses and for sole on-line courses.
- The view that on-line provision was cheaper for higher education institutions was contested on grounds of set-up costs and staff time required to support on-line learning.
- Evaluations of blended learning courses indicated preference for more face to face sessions and were regarded as a better format for facilitating certain aspects of learning.

7.4 Delivering the mentorship course: supporting learner mentors

The mentorship course was spread over a period of weeks and for the learner mentors this entailed regular study days interspersed with periods back in practice during which time they had episodes of supervision and support from their mentor buddy. Sustaining motivation and keeping up with course assignments could be challenging to maintain alongside work and other commitments and all participants were asked about the support with which learner mentors were provided during this time from both HEI and trust personnel.

Participants’ views on support from HEI personnel are presented in Section 7.4.1, first the HEI participants and then those of their trust counterparts. In Section 7.4.2, the focus turns to support for learner mentors from trust personnel, first the views of trust participants and then those of their HEI counterparts.

7.4.1 Support for learner mentors from HEI personnel

HEI participants’ views on support for learner mentors from HEI personnel

Most of the Group A participants (9/11) but fewer of the Group B participants (4/11) regarded themselves as having sufficient knowledge of support offered to learner mentors by the HEI to be able to comment. Support was provided in several ways: discussion with the course teachers (or the course leader) through phone, email or ‘blackboard’; one-to-one sessions with their course teacher; and access to on-line resources such as the practice education portal at HEI-1 which hosted all the material relevant to the course, and the library of e-learning resources at HEI-2. One-to-one sessions were usually requests for assistance with writing assignments and, as noted in Section 7.2.3, the need for this was sometimes identified by the course teacher on the basis of learner mentors’ first piece of written work.

Support was also provided by link lecturers while visiting their practice areas. In Group A, the link lecturers might also be course teachers:
“I saw one of my group yesterday when I was out in practice. She knew I was going to be there so she said can you come and see me for half an hour? So I can keep a link with them.” (HPL1)

When visiting students who were placed in nursing homes, a lecturer who linked with this sector observed that this provided an opportunity to meet with staff attending the course and enquire about their progress and if they needed additional help. At HEI-2, a link lecturer noted that they tried to ensure that nurses in their practice area attending the course had a student to mentor.

**Trust participants’ views on support for learner mentors from HEI personnel**

Most of the Group A (4/6) and Group B (7/9) trust participants regarded themselves as having sufficient knowledge of support offered to learner mentors by the HEI to be able to comment. Their views endorsed the forms of support identified by the HEI participants. While most regarded the support as adequate on the basis of lack of negative feedback from learner mentors, a few expressed concerns about aspects of support.

The link lecturers were identified as the person from whom support could be obtained; however one of the PEFs expressed the view that the number of link lecturers was decreasing and so the amount of support from the HEI was correspondingly decreasing; manifest in this participant’s view by lack of support for learner mentors undertaking assessments when in practice. One trust senior educationalist knew that some staff in the trust struggled with course content as they found it more theoretical than they had anticipated and expressed concern about whether HEI course teachers were always aware when learner mentors were struggling, particularly those who were diffident about requesting help.

### 7.4.2 Support for learner mentors from trust personnel

**Trust participants’ views on support for learner mentors from trust personnel**

Most of the Group A (4/6) and Group B (8/9) trust participants spoke about trust support for learner mentors. Personnel providing support included: the clinical lead and the practice teacher for the team in the primary care trusts; the mentors in the hospital trusts; and the PEF, clinical supervisors, practice setting managers, mentors and sign-off mentors in the mental healthcare trusts. Some of these personnel were acting as a mentor buddy for the learner mentor. A primary care trust participant added that it was difficult to know about support in all the practice settings that comprised the trust as these were very widely spread out.

For each of these trusts, participants observed that the level of support might vary by practice setting. The importance of support and the need for consistency throughout a trust was reflected upon in depth by one of the PEFs:

“I think having the notion of having a student while you are learning how to be a mentor and having a very open dialogue is good practice. But equally having someone who’s mentoring you through that mentoring process and getting you thinking about and challenging you and getting you reflecting on ‘well why did you make that judgement, what evidence did you base that judgement on, what other factors might you have taken into consideration in thinking about this?’ So I think again in pockets, that goes on. But ideally it would be good to have that more consistently across the piece.” (TPEF3)
Strong leadership in placement areas was seen as important in creating a supportive environment for learner mentors.

**HEI participants’ views on support for learner mentors from trust personnel**

Turning to the views of HEI participants on trust support for learner mentors, most in Group A (10/11) but fewer in Group B (4/11) had sufficient knowledge of circumstances to feel able to comment. Mentor buddies and PEFs were the personnel most often identified as providing support. For the mentor buddy this entailed: helping learner mentors negotiate what they needed to do in practice to support the theory component of the course; offering practical advice and guidance; discussing assignments such as planning the learning sequence; and signing them off in the mentor buddy booklet to confirm that they had taken part in planning learning and assessing the student. Like their trust counterparts, some of the HEI participants observed that support varied within and between practice settings. This variation was attributed both to the quality of mentor buddies and the learning culture within the practice area.

On the basis of discussions with learner mentors, participants said that some reported that their mentor buddy went through everything with them really thoroughly whereas reports from others made ‘you wonder if they have even met them’. A programme director described the impact of variation thus:

> “Again it comes back to the idea of if you’ve got a mentor who does his/her job properly then if they are supervising, or actually mentoring a mentor then hopefully that’s a role model and would come across. I do think that a lot of the time you do model yourself on what you see someone else do in practice and you bring your own personality and characteristics to it.” (HPD3)

Some participants thought that lack of support might be due to supervising mentors being too busy with the demands of mentoring pre-registration students to give their full attention to learner mentors. Others observed that lack of support had arisen particularly in small placement areas in primary care trusts where there might be only one qualified mentor who was also supporting pre-registration students and this was contrasted with acute care settings where more staff were on hand to provide support for both learner mentors and students.

Variation in the quality of support was also attributed to the learning culture. Thus a senior educationalist remarked that places where support for learner mentors was excellent were those that tended to be well managed in every other way as well, while a mentorship course teacher observed:

> “If the ward manager has got a real commitment to everybody learning, a very reflective practice, then I think that trickles down.” (MPT1).

One of the programme directors with an active link to practice said that learner mentors in the area met regularly with senior clinical staff, their progress was overseen by the PEF and they had the opportunity to meet in the education centre to share their experiences. This participant attributed good support for learner mentors to a positive attitude towards mentorship running throughout the trust. Thus senior trust personnel took the view that having a really good mentorship programme would increase the likelihood that students will be well mentored and this, in turn, would increase
the likelihood that these students will feel that they would also be well supported as staff nurses and so hence wish to work in the trust after qualification. Other examples of supportive environments included: a manager giving a staff member extra days study leave when they had to retake the module; and nursing home staff being supported by managers and colleagues who had already completed the course. Examples were also given of unsupportive cultures where the attitude towards learner mentors was one of ‘we have given you this time now get out there, do the course and come back.’

7.4.3 Key points on support for learner mentors from HEIs and healthcare providers

- Both HEI and trust participants concurred with the perception that HEI personnel provided support for learner mentors during the course in a diversity of formats including one-to-one sessions based at the HEI and in learners’ own working environment.

- There was some concern on the part of trust participants that decreasing numbers of link lecturers was reducing the amount of support available from the HEI.

- Both trust and HEI participants concurred with the perception that trust support for learner mentors was provided by a diversity of personnel, some acting as mentor buddies.

- Both groups of participants acknowledged that the level of support could vary by practice setting and attributed this to variation in the quality of mentor buddies and also to the quality of the learning environment engendered by leadership in the setting.

7.5 Delivering the mentorship course: challenges for module leaders and teachers

When asked what challenges delivering the mentorship course presented, participants’ responses fell into five main topics; aspects of the administration entailed in running the course (7.5.1); teaching students with diverse educational backgrounds (7.5.2); addressing the impact of various sources of influence on course members (7.5.3); preparing learner mentors for aspects of the course, especially assessment of students (7.5.4), and challenges in the way that learner mentors are assessed (7.5.5).

7.5.1 Challenges of running the course

Both programme leaders spoke about various administrative challenges that the course presented. The leader in HEI-1 observed that it was not just the numbers but the fact that the students came from so many different practice settings made it difficult for her to keep abreast of all the issues that might affect learner mentors in practice such as making sure that they had access to all the resources that they needed. The administrative workload prevented the programme leader from visiting learner mentors in practice, a course of action she felt would have been desirable in terms of ensuring quality, and hence much reliance was placed on the link lecturers to ensure that students’ needs were met. While having fewer numbers of people taking the course would make the programme easier to manage and monitor, it would be regarded as ‘financial suicide’ by the HEI management.
A senior educationalist at this HEI corroborated the challenges presented by the numbers taking the course:

“So you have to be incredibly organised because you are overseeing a huge number of groups....... So managing your marking, moderation, making sure that you’re getting your groups filled up appropriately so that you don’t have lots of semi filled groups, so logistics is the big thing, and then the liaising and ensuring consistency across the piece. It’s enormous it’s bigger than the pre-reg nursing curriculum in some ways.” (HSE1)

Large numbers of students were also a challenge at HEI-2 with 120 students on modules at any given time. The programme leader here spoke of the challenge of ensuring that there was co-ordination among the team as to what was being delivered, getting people to return assignments when required, and making sure that she had an overview of every stage of the administrative process. A particular issue at this HEI had been that at one stage after the team had marked and moderated the module it was sent to an assessment board on which they were not represented and thus did not have the opportunity to learn about the quality assurance mechanisms applied to the module and how it might be improved. The programme leader described a successful campaign for a separate assessment board for the module prior to results being forwarded to the main assessment board:

“I mean it’s more administration but I think it helps us to know exactly where our module stands... the quality component has to be integral. And if you’ve been denied that bit, actually there’s no impetus for you to improve.” (MPL2)

7.5.2 Challenges of teaching students from diverse backgrounds

All those who taught on the course spoke about the challenge of a course membership that comprised students with diverse educational backgrounds in terms of both their level of qualification and learning styles with which they were familiar.

A proportion of the learner mentors were overseas nurses and some had difficulties in adopting a very different learning style from the didactic approach with which they were familiar; difficulties that could be compounded if English was not their first language. Among those who had been trained in the UK, different learning styles were also evident; so whereas some came from a tradition of nurse education that entailed learning from ‘being told what to do’, other more recently qualified nurses were used to action-learning and problem-based learning. Some learner mentors had qualified over 20 years ago as state enrolled nurses and had gone on to qualify as registered general nurses, other learner mentors were already qualified at first and second degree level. Not only did course members have diverse educational backgrounds, they also came with different expectations about what might be achieved on the course and concerns were expressed that class numbers were too large for the teacher to be able to meet everyone’s needs.

Differences in students’ educational background was more likely to be evident in the ease or otherwise with which they could undertake the academic course work rather than being able to translate the theory of mentorship into practice. Participants referred to identifying those who might need extra assistance on the basis of reading assignments undertaken near the start of the course and then offering them help with study skills and essay writing:
“And so I can spend extra time with them over this – just to give them guidance. Because we’re not here to fail people. We’re here to support and help them.” (HPL5)

Participants from both HEIs queried whether the levels at which courses were offered were necessarily appropriate for all those who wished to become mentors. A particular example was given of a level 5 course attended by people ranging from Band 8 team leaders taking the mentorship module as part of a masters’ degree to people who had very different educational backgrounds and whose English was not very strong. The view was expressed that a level 5 course did not adequately meet the needs of either group and that it would be preferable to teach the former group at masters’ level and the latter group at level 4. However, capacity was not available to offer two separate courses.

The question of appropriate level of course was raised in particular in relation to staff working in nursing homes. As noted elsewhere (Chapter 6, Section 6.5.7), nursing homes were becoming an increasingly important part of the placement circuit and hence their staff were being encouraged to qualify as mentors. A senior educationalist at HEI-2 said that the level 5 course was the same level as the final year of a degree and they had found when opening the course to staff from nursing homes that although they were excellent nurses some did not have the academic background to undertake a level 5 course and struggled to produce the work required. (NB it is level 6 that is equivalent to the final year of a degree). Failing the course was dispiriting for the staff and also affected mentorship capacity in the nursing home sector. This participant added:

“So I think there’s a bit of tension there between the academic demands and the academic pretensions of the programme and the actual needs, what do we really need, what are we really looking for here, why are we doing it at level 5? We need to explore this over the next year.” (HSE3)

Similar concerns about the negative effect on staff attending a course at an inappropriate level were made by a lecturer at HEI-1 who linked with nursing homes:

“Our people want to do the mentorship course. They haven’t done much studying especially in nursing homes, therefore that needs to be taken into account first. You need to be checking whether they have the ability to study at that level. If they haven’t, say you have recruited people who haven’t got a diploma, therefore you need to bring them to that level otherwise the expectation is greater than what they can deliver and I think that’s not fair.” (HPL4)

7.5.3 Influences of motivation, working circumstances and education experiences

Those teaching on the course spoke of the need to respond appropriately to various sources of influence that might affect learner mentors’ approach to the course: their motivation for taking it, their working circumstances and their own experiences of student nurse education.

Participants attributed diverse sources of motivation to learner mentors for taking the mentorship course and these included: career progression; other personal benefits; enjoyment of teaching; commitment to the profession through developing others, and being sent by a ward/service manager to meet mentoring needs of the organisation (Chapter 5, Section 5.2.3). There was a consensus among participants that diverse motivations made no difference to the way the course
was delivered; however several spoke about the challenge of knowing that some of the course members did not want to be there and described various approaches to trying to increase their motivation. One reported doing this in a ‘jokey’ way that enabled people to admit if they had been sent on the course rather than having chosen to take it and then encouraged course members to talk about their own experiences of being mentored and found that this usually provoked lots of discussion about bad mentoring experiences:

“And I’ll let them talk all that out and then I’ll say, ‘I wonder if they were a mentor because their manager sent them. I wonder if they were a mentor because they wanted a Band 6’? And then you see the faces and the realisation.” (HPL2)

Another participant described starting the course with a ‘values clarification exercise’ about what it means to be a mentor, what kind of mentor they hoped to be, what are the barriers for getting there and what are the enablers. The answers given were then used as basis to build on as the course progressed.

Maintaining motivation during the course was seen as important and could be difficult for teachers on courses when course members made it obvious that they did not want to be there, maintained that what was being advocated would not work in their practice area, or were really struggling to balance the course with family commitments. Participants referred to constantly having to demonstrate the value of mentorship to maintain motivation; one described an approach of trying to build on positive progress by starting each study day by asking course members what they have learnt about themselves as mentors since the last session and another found that as the course progressed, people’s perspectives changed:

“Once they were all interacting with each other and I was delivering the content, I think that their perspectives changed because they were learning so much. And also because you were reminding them of their role as qualified staff and their accountability and responsibility.” (HPL5)

One participant summed up the challenge of increasing motivation by saying:

“That’s the challenge, my challenge is to get them at the end of the course, as enthusiastic about nurse education as I am.” (HPL2)

People brought to the course a diversity of experience in relation to their own nurse education and it was important that their ‘hang-ups and history’ in relation to these were addressed during the course so that these did not influence their own approach to mentoring students:

“One of the great challenges for us is getting them to reflect on custom and practice and to say ‘Just because this is how I was mentored and just because this is how my colleagues mentor, it doesn’t mean that this is the way it always has to be’.” (MPT1)

It could also be challenging when discussing the translation of mentorship theory into practice to understand the stresses and tensions that clinical staff could be faced with and to help them to deal with these at the same time as mentoring students to the best of their ability.
7.5.4 Challenges presented by aspects of the course objectives

Two aspects of the course were identified by participants (11) as presenting a particular challenge: developing an understanding of the role of the mentor, and accepting and understanding the mentor’s role in assessing student competence.

Developing an understanding of the role of the mentor

Helping learner mentors develop an understanding of the role of the mentor posed challenges and these included: getting people to acknowledge that they have the skills to fulfil the role and then helping them to develop these further; understanding that they have responsibilities to the NMC and to the profession and are accountable for their actions as mentors; and on the one hand alerting learner mentors to the risks that are associated with the role but on the other not scaring them too much to be able to be effective. Inculcating desired approaches to mentorship could also be challenging. The role of mentor involves encouraging students to ask questions about, for example, why a procedure is carried out in a certain way, and there was recognition that this may be harder to develop among nursing home staff who might not be working in an evidence-based culture.

Accepting and understanding the mentor’s role as assessor

Enabling learner mentors to accept that their role included assessing student’s competence, being able to give feedback to students, and understanding the responsibilities and accountability entailed in making assessments were regarded as particularly challenging aspects of teaching the mentorship course.

Participants observed that assessment was the part of mentorship with which learner mentors felt least comfortable:

“They don’t want to be the assessor. They are happy to be the facilitator, the guide, the coach, the mentor, the friend. They’re happy with every other element of the mentorship role. That sounds like a lovely thing to do, except ‘oh I’m the assessor’. That’s the hard thing.” (HPL2)

Meeting the course objectives meant ensuring that learner mentors understood that assessment of the pre-registration student had to be embedded throughout the period of a placement and that this required spending time working with the student in order to be able to make judgements about competence; it could not just be deferred until the end of the placement. The course teachers emphasised that mentoring was about having pride in the nursing profession and recognising the importance of a role that entailed making judgements about who should become members of the profession. But it was acknowledged that telling a student that they were not progressing well was one of the most difficult subjects that the module dealt with and that this required much attention on the course:

“It’s easy isn’t it, to sit down with somebody and say ‘You’ve done really well love, brilliant.’ But breaking bad news? You’d think as nurses actually we’d be a little bit better at it than perhaps somebody who isn’t [a nurse] and actually most mentors find that really difficult. Because you have to do it face to face. And it’s not nice, telling somebody ‘You’re not doing too well are you? I think you need to do something about this’ and they need to be taught a way of doing it that is not soul destroying, that actually is constructive, that actually makes the student think ‘Yes I’m not doing so well but actually I could do something about it’.” (HPL6)
Some participants observed that there was a tendency on the part of learner mentors to focus on how to fill in the assessment book. The aim of the course however was for learners to understand the process and the principles of making a record of their assessments since all the forms of evidence would be important if an assessment was challenged. Moreover the precise format of the book could differ between trusts but the process and principles were the same. Other challenges included enabling learner mentors to prioritise what was important in making an assessment and, in particular, passing a student if they met the criteria even if they did not like the student personally, and recognising that accountability for their decisions was fundamental to their role:

“The challenge is to get them to understand that they’re responsible entirely, 100%, for the assessment of students in practice. That is their accountability and responsibility.” (HPL2)

### 7.5.5 Challenges of assessing learner mentors

Several participants (5 HEI and 5 trust) thought that aspects of the way in which learner mentors were assessed presented a number of challenges.

**Assessment of written assignments**

A first point re-iterated concern already expressed about whether the level at which the courses were offered was necessarily appropriate for all those who wished to be mentors (Section 7.5.2). Assessment at one of the HEIs included a 3000 word essay that entailed reflection on various aspects of being a mentor and one of those teaching the course found that the completed assignments reflected the diverse educational backgrounds of the course members. This participant was not convinced that this essay was the best way to assess all learner mentors and a different approach would not then disadvantage those who struggled with essay writing:

“I don’t think it’s the best way to assess some of these students. What we want is competent mentors, we don’t need them writing level 5 degree level essays.” (MPT1)

**Assessment of supervised practice**

Most of the observations about assessments of learner mentors focused on the practical component of the course and in particular supervision by mentor buddies (Section 7.2.2). It is of note that there seemed to be a difference between participants in the way in which they referred to this; thus some described the supervising mentor as making an assessment of the learner mentor while others stated that their role was not one of assessment but rather one of supervision and verification of what the learner mentor had undertaken. Notwithstanding this potential confusion over terminology, three aspects of concern about the assessment of learner mentors by mentor buddies emerged from observations made by HEI and trust participants:

**Variation between supervising mentors**: Examples of comments included firstly a PEF:

“It goes by who’s doing the assessment. If that person is enthusiastic about their role and is well-equipped, they’ll do a good job of it. If they’re not then they won’t. And I think that’s the structure that we have and that’s the kind of risk you take with that sort of structure.” (TPEF8)

And second, an HEI programme director:
“It all comes down to who’s mentoring the mentors. It comes down to who’s signing them out of practice areas.” (HPD3)

Robustness of the process: Concerns about the robustness of the supervising mentors’ assessment of the learner mentor had resulted in the advocacy of different approaches; as observed earlier, one HEI, in response to NMC concerns about robustness of supervision, had developed a competency portfolio for supervising mentors in order that they might all take the same approach to verifying what the learner mentor had achieved (Section 7.2.2).

“The challenges for us are that we don’t see what happens in practice and we are beholden to the supervising mentor to give us feedback at the end of the module. Each supervisors’ approach to assessment can be different and how they fill in the form completely differs one from another – so that’s why we developed the competency document.” (MPL2)

The issue of concern for one of the HEI senior educationalists was that during many years of involvement with the course, a learner mentor had never been failed on the practical component and that this, given its likely implausibility, undermined the validity of the supervising mentor’s assessment.

Appropriate person to make the assessment: One of the PEFs stressed the importance of the supervising mentor being more experienced and at a more senior level than the learner mentor:

“Because imagine a staff nurse assessing another staff nurse, the confidence to say to another colleague at the same level ‘you’re not good enough’ is rather daunting.” (TPEF2)

Another PEF had given some thought as to whether it might be preferable for learner mentors to be assessed in practice by the HEI staff delivering the course as there would then be a consistent assessor for each group of learner mentors. On the other hand, the HEI course teachers were unlikely to be clinically up to date with all practice areas in which the learner mentors were working and so would not be able to judge if the learner mentor was assessing a student’s competence appropriately. Hence both options, the current one and alternatives posed a risk of some kind.

7.5.6 Key points on challenges of the course

- Numbers taking the course and the need for cost-effective organisation led to heavy administrative workloads.

- Meeting needs of course members with very diverse educational backgrounds required time and sensitivity in ensuring that everyone’s learning needs were met and raised questions about the appropriate levels at which the course was offered.

- Teachers had to be able to respond to the way in which learner mentors’ approach to the course might be influenced by: motivation for taking the course; poor experiences of nurse education; and stressful working circumstances.

- Enabling learner mentors to deal with assessing student competence since it was the aspect of the mentor’s role with which they felt least comfortable.
• There were concerns about the appropriateness of the written assignments as the best means of assessing all would be mentors and concerns about the quality of supervision of learner mentors in the practice setting.

7.6 Adequacy of course in preparing mentors for their role
The foregoing sections have presented findings on the format, aims and content of the course and aspects of its delivery: pros and cons of face to face and on-line modes of provision; supporting learner mentors during the course; and various challenges that it presented. So how did participants perceive the adequacy of the course in preparing mentors for their role? Of the 22 HEI participants, 18 knew sufficient about the course to give a view. Of the 11 at HEI-1, six were teaching on the course at the time of the interview and three had relatively recent experience of so doing. Of the 11 at HEI-2, two were currently teaching on the course, another had previously done so and six had views about adequacy of preparation mainly on the basis of working with mentors in practice. All 15 trust participants replied on the basis of learner mentors’ reports and observations of their subsequent work as mentors. The same themes emerged from the responses of HEI and trust participants with slightly differing emphases.

7.6.1 Overall quality and adequacy of preparation

HEI participants: views on preparation overall
The six involved in teaching the course at HEI-1 and the two at HEI-2 regarded the academic part of the course as being a good preparation for all aspects of the mentor’s role. A variety of rationales were given for holding this view: pass rates had improved tremendously over time; seeing some of the course members working as mentors in practice indicated that the course had been a good preparation; and most learner mentors reported at the end of the course that they were far more confident of the knowledge base that underpins mentorship than hitherto.

“I think it gives them a very good overview of what they need to do in terms of the process and following the process and how to actually organise learning, how to structure learning so that the students learn everything that they are meant to learn.” (HPL3)

This positive perception of the academic aspect of the course was echoed to a greater or lesser degree by other HEI participants; observations included ‘mentors report that it was good and a useful course to do’, ‘it gives them support and encouragement and helps them see the wood from the trees’ and ‘it makes them think about their practice area becoming part of the placement circuit if not so already’.

Two HEI participants however queried whether the course had any impact on mentoring effectiveness; one thought that staff relied more on how they themselves were mentored rather than on what they had learnt on the course while the other questioned the evidence base on the subject:

“If I’m completely honest I would say there’s no evidence at all in the country that attending a mentorship programme makes you a good mentor. There’s no research to demonstrate that makes any difference. We never used to have mentorship courses and there is no evidence. The
fact that we know that significant numbers of mentors fail to fail students would suggest no and that’s across the country.” (HSE1)

This participant went on to comment however that if staff were natural teachers then the course would most likely add to their skills.

Trust participants: views on preparation overall

Trust participants gave a more diverse range of responses in relation to overall adequacy of the course. Seven described the course as a good or adequate preparation and reference was made to the course giving students a good insight into how to provide a learning environment and understand different learning styles. These positive observations were based on: feedback from mentors; increasing pass rates; good reports of mentoring by students’ in their placement evaluations and hence by implication a course that had prepared the mentors well, and lack of negative feedback about the course.

“I believe that you don’t have people going on the course and coming away and saying what was that all about – which could be the case.” (TSE1)

Some trust participants drew attention to aspects of the course for which they felt learner mentors were least likely to be well prepared. Assessing student competence was mentioned most often but reference was also made to insufficient linking of feedback to the outcomes and professional behaviours expected of students and to managing difficult situations, for example when student performance was affected by personal problems.

Two trust participants took the view that a judgement about the adequacy or otherwise of the course could not be made without an evaluation of its impact. A PEF holding this view said that this would entail knowing people before and after they went on the course and while this might be possible with staff who worked in wards, this would be much more difficult in the community with staff scattered over diverse settings and often working alone. For a trust senior educationalist, the issue was one of the trust having insufficient resources to evaluate the courses it commissioned and, in the absence of evaluation, it was not possible to know how adequately or otherwise the course prepared staff to be mentors.

Another two participants, both from mental health trusts, thought that the course was too short to do justice to the complexity of enabling learner mentors to facilitate the learning of student nurses and then learn how to assess what the student has learnt:

“I think it is a really difficult skill to learn in that three month period….So I have some concerns as to whether actually we are selling mentors down the river and setting them up to fail to a degree and therefore that has an impact on the student and the student’s assessment and learning, and eventually the fitness to practice of that student.” (TPEF3)

Both however, recognized that cost implications meant that a longer course was unlikely.

7.6.2 Variation by course member and teacher

Some HEI and trust participants thought that the extent to which the course was an adequate preparation depended on the individual learner mentor. Some staff were described as responding
well to the course, others not. Adequacy of preparation could depend on how much the learner mentor was prepared to put into the course and this, in turn, was seen as depending on whether or not they wanted to be a mentor or were taking the course for collateral reasons.

Three trust senior educationalists drew attention to the importance of good quality teaching in the preparation of learner mentors as the following examples show:

“One or two said they had found one or two of the lecturers are quite positive about mentorship and it energised them about the process of supporting the students in practice. Others found they were ok. So in a lot of cases it depends who teaches it.” (TSE2)

“You could have the most inspiring educator in the world teaching you and you come out and you are really raring to go, and actually you get it because of the way it’s been taught.” (TSE4)

7.6.3 Translating course content into practice

Adapting course to practice circumstances

Among the HEI participants, some who taught on the course and others, the main caveat that emerged concerned translation of course content into practice. Participants observed that while the course prepared learner mentors very well theoretically, the course teachers had no control over the clinical environment in which the newly qualified mentors would be deploying their skills and knowledge and that it was up to the mentors themselves to manage this environment in discussion with the manager of their practice settings. In one such example, the participant drew an analogy with adequacy of preparation of pre-registration students:

“In the same way we teach our students, in the classroom you are able to look at the NMC domains or standards or whatever, but of course the reality is it’s the environment of the practice area that really shapes our students and the mentors.” (HPD4)

From the perspective of trust participants who commented on translating course content into practice, the main point was a need for a greater focus on this during the course HEI-based study days, namely ‘how to translate what is learnt in the classroom into a very practice based environment’. One of the PEFs who made this point went on to compare this with ideal and actual practice in a client’s home:

“And it’s kind of like adapting it so you’re not doing it textbook style but it’s good enough sort of thing or it fulfils the needs of students. But sometimes you have to be a bit more creative on how you actually do that. So you think well we learnt all this stuff in the classroom but how do you apply it in practice. So it’s like anything you learn. It’s like you learn aseptic technique and you go out to a client’s home and you’ve got the cat wandering across your aseptic area, you know, you have to think, Okay, don’t worry about it, just…….” (TPEF7)

A trust senior educationalist from a mental health trust raised the question of whether a mental health specific course would increase its relevance to staff in that it might focus less on the ‘bigger picture for mentorship’ and more on how they might apply the skills learnt to their particular setting. For an HEI senior educationalist, the problem lay in the increasing academic nature of the course
once it became a module in the degree pathway, and a concomitant loss of focus on its practical aspects.

**Supervised practice during the course**

In discussing the adequacy of the course, some participants referred again to concerns already expressed about the variability in the quality of supervision received from mentor buddies. In making a judgement on how adequate or otherwise this aspect of the course had been, one of the mentorship programme leaders made the point that the HEI team did not necessarily have the information to make this judgement:

“Yes, I think in some respects practice is almost the great unknown. We know some of what happens because the PEFs will report back to us, but I think that the relationships that occur between the students and supervising mentor and learner, I think, are very variable, and where we know there is a problem we can intervene, we can find out what’s happening, we can get the students the support they need. But again, when you’ve got students who aren’t very empowered to say ‘There’s a problem, actually my sense of confidence is diminished’ whether not they get a glowing supervisor evaluation and are able to write a good essay or not.” (MPL2)

And one of the senior educationalists expanded on this point by arguing that it was important to ensure that supervision of the learner mentor was undertaken by someone experienced, with link lecturers, key mentors and PEFs all identified in this respect.

**A period of supervised practice after the course**

Two of the HEI participants, one from each HEI, thought that translation into practice would be facilitated by having a period after the course when the learner mentors could be assessed in practice assessing students, rather like a ‘preceptorship’ period after initial qualification. One of these two also thought that the course should be longer but observed that neither this nor a period of supervised practice was likely given pressures on resources and the fact that placements areas were desperate for mentors to start mentoring as soon as possible.

**7.6.4 Key points on adequacy of course as a preparation for the role of mentor**

- Most participants regarded the course as a good or adequate preparation overall with attention drawn to several particularly beneficial aspects of course content.

- Views were also expressed about the need for an evaluation of course impact before conclusions could be drawn about its adequacy or otherwise.

- There was recognition that the extent to which learners benefitted from the course depended on what they were willing to put into the experience and on the qualities of individual module teachers.

- Adequacy of the course in relation to translation into practice was seen as related to: the need for a greater focus on this during the HEI-based study days; the quality of supervision of the learner mentor in practice, and the desirability of having a supported period of practice after the course.
7.7 The mentorship teacher: qualities, choice, preparation and support

Thus far this chapter has focused on the education provided for learner mentors and the input of various personnel into this enterprise. The focus now turns to the key post-holder in this respect, the mentorship teacher, a subject that was explored with the HEI participants (10 of the 11 at HEI-1 knew sufficient about the post to comment as did 9 of the 11 at HEI-2). Attention focuses first on the skills and qualities that participants thought mentorship teachers should possess (7.7.1) and whether or not it should be regarded as a specialist role (7.7.2). The extent and format of preparation provided for the role and subsequent support are considered in Section 7.7.3.

7.7.1 Qualities needed for teaching mentorship

A range of attributes, knowledge and skills for teaching on the mentorship course were identified by those involved.

**Attributes**

Having enthusiasm and a passion for nurse education were described as essential attributes for teaching mentorship. In the words of one of those teaching on the course:

“**A passion for nurse education. And I think the word passion, because it isn’t the glory role, it really isn’t. It’s far more glamorous to say that you teach on the cardiothoracic course or the… it’s not the glamour role in any university anyway, nursing… and in terms of the pecking order of mentorship compared to other courses, I think we’re probably well down. So I think it takes a passion. I think it takes a particular type of person, or interest.**” (HPL2)

Other attributes included openness, flexibility and reflectiveness with some commenting that these were similar attributes to those desirable in the mentors themselves. Having an awareness of the stresses that staff can be under in very busy clinical environments was also mentioned, as was staying hopeful:

“**You’ve got to stay hopeful, because people come in there with huge negativity about students, and you have to completely turn that on its head.**” (HPL3)

**Skills**

A diverse range of skills were identified. Enabling learner mentors to develop the skill of being able to generalise from the specific was required in the sense of teasing out the learning implications of a situation and then applying these to different situations. Encouraging learner mentors to focus on the positive was advocated by way of concentrating on the pre-registration students who do well and on those who are borderline, and recognising that there are only a few students who are not progressing well, albeit that they often ‘cause the biggest headaches.’ Role modelling by teaching well was mentioned on the grounds that if learner mentors are taught well by course teachers and by supervising mentors, then this experience will influence how well they teach the pre-registration students. Being a good facilitator was a skill noted as being particularly important when teaching staff from nursing homes and enabling them to see that although they may not come from an evidence-based culture they nonetheless have much to offer students.
Knowledge

The aspect of knowledge most frequently referred to was to have an understanding of the role of the mentor and to be able to give examples of mentoring that were based in practice. For the course teacher this meant an awareness of circumstances of branches of nursing other than their own (or of all branches if not a nurse), since course membership was multi-branch. Other aspects of knowledge regarded as essential included: keeping up to date with the pre-registration curriculum and linking teaching about student learning to its requirements; having a good knowledge of the history of nurse education; and being completely up to date with the requirements of the NMC standards for learning and assessment.

7.7.2 Becoming a mentorship teacher: criteria for taking up the role

Providing people to teach the mentorship course is a key component of the capacity that supports the delivery of mentorship and, as with the debates about mentors and sign-off mentors (Chapter 5, Sections 5.4 and 5.10), raises questions over whether it should be a generic or specialist role and whether staff should have a choice about taking it on.

HEI-1 participants’ views on criteria for the role of mentorship teacher

At HEI-1, the driving principle behind developing the mentorship team had been to only appoint people who wanted to teach on the course and whom the senior educationalists believed were committed to the endeavour; in the words of one of them:

“A few years ago I made it very clear that I wanted us to be selective over who taught it. In other words I only wanted those people who I believed were committed to practice, had clinical links and had a commitment to mentorship.” (HSE1)

These points were further elaborated by the other HEI participants. Some focused on the importance of commitment to mentorship when delivering the content of the module:

“I think it is a module that one has to have a special interest in mentoring, to be able to get the topic across in an interesting way. Because I think it’s probably a topic that could be very dry if you weren’t enthusiastic about it. And whilst on paper I think we can all teach the principles, I think if you’re not interested in it, that would come across.” (HPD2)

Having a clinical link was regarded as essential by HEI-1 participants as otherwise teaching would be a theoretical exercise only without an understanding of how this might translate into practice. Although this group of participants regarded knowledge of mentorship and a commitment to practice-based education as important requisites for teaching on the module, the view was also expressed that all link lecturers should undertake the role at some point as it was an excellent way of keeping up to date with issues affecting mentorship and with the NMC standards.

All the learning community education advisors taught on the course, a responsibility that was included in their job description. Decisions about who else should teach on the course were considered in the context of the annual allocation of workloads and the perspectives that different members of staff would bring to the course team, as one participant put it ‘so we have a floating team really’. There were some concerns that the freedom to include only those who wanted to
teach on the course and were committed to mentorship might be curtailed in the face of downsizing of the faculty’s lecturing workforce.

**HEI-2 participants’ views on criteria for the role of mentorship teacher**

The question was approached slightly differently by the HEI-2 participants to reflect the particular circumstances in their HEI. The teaching team comprised a mixture of nurses and non-nurses and this blend of perspectives on mentorship was regarded in a positive light. The depth of specialist experience and consistent approach developed by the team was regarded as reflecting the importance attached to mentorship given the public protection issues that it addressed. As with HEI-1, possible changes were under consideration that might involve other members of the lecturing staff becoming involved, as indeed had been the case prior to the establishment of the separate unit. While there was recognition that other link lecturers could usefully contribute to the teaching team, some concerns were raised about the implementation of such a change. A senior educationalist and a programme director queried the impact that this might have on the workloads of the departments from whom such staff might be drawn and stressed that such a commitment would have to be adequately built into agreed workloads. Furthermore, staff who might be involved would have to be able to participate on a long-term basis to avoid an ad hoc approach:

“Anybody should be able to take it on but I don’t think it’s one of those things where you should be used as stopgap. If somebody’s short of a module I don’t think ‘Oh can you teach this for this module’. I think either you do it or you don’t. OK you might want to do it for a year or six months but not this jumping in and out just as an ‘oh well we’re a bit stuck for someone, do you mind?’”

(HPD3)

Moreover, as some participants observed, preparation and guidance before assuming the role would be required; a point pursued further in the following section.

### 7.7.3 Preparation and support for the role of mentorship teacher

Participants who taught on the mentorship course had varying backgrounds; they had in common a knowledge of mentorship but differing qualifications in relation to educational theory and research and for those who were nurses, differing experiences of clinical practice, education, research and management. In recognition that bringing these diverse backgrounds to bear on teaching the mentorship module required some preparation, both HEIs provided an induction programme for those new to teaching the module. Participants also described the format of ongoing support and involvement in course development.

**Induction and support for new mentorship teachers**

Both mentorship programme leaders described their induction programmes and these included: sitting in on sessions to observe other teachers and to get a feel of the approaches taken; the provision of tutor guides; team teaching with experienced lecturers; preparation for teaching aspects of the programme; and then solo teaching while being peer reviewed by an experienced lecturer and before taking sessions alone.

There was recognition that teaching could be quite challenging over, for example, teaching such mixed ability groups and encountering diverse levels of enthusiasm about attending the course.
Those participants who were fairly new to teaching reported their appreciation of the support received at the outset. Describing the range of support, one commented:

“So I had a lot of help coming from all corners really.” (HPL3)

And another who had just taken her first course:

“And so you just have this anxiety, because I’ve never delivered it before, about you know, how is this going to go, how am I going to perform. But as I said, the site I thought was really well developed and I prepared myself by looking at it. Also having a discussion with my programme leader. And she was really supportive. And I said to her bear with me and she said I’m going to come to you. This was my first delivery and she was very good.” (HPL5)

**Regular meetings and ongoing support**

Regular meetings of the mentorship teams at both HEIs also provided opportunities for support, especially for new team members, and an opportunity to share ideas about activities and approaches that individual members had been developing. Meetings were held with all those involved with each intake of learner mentors to discuss course structure and content and particular issues that this group might present. After moderation events, the teams met to consider how best to take the module forward and one participant observed this also included consideration of how to make it interesting for themselves.

“As it can get boring doing the same thing over and over again and it’s important that we remain enthusiastic.” (HPL3)

The importance of the programme leader in providing direction and support was acknowledged; for example:

“We have an excellent programme leader, we have a programme meeting three times a year, straight after a moderation event. So I don’t think I need anything else. It’s all down to the programme leader.” (HPL3)

And in recognition that programme leaders also needed support, at least one of the HEIs provided an in-service course on the role of programme leader and both incumbents of the post spoke positively about the support that they received from their own line manager.

**7.7.4 Key points on the role of the mentorship teacher**

- Qualities regarded as desirable for mentorship teachers included a range of attributes (in particular enthusiasm for, and commitment to, nurse education); skills (facilitating learning of members with diverse backgrounds, role modelling) and knowledge (issues for all branches, curriculum, NMC standards).

- Both HEIs regarded commitment to nurse education as an essential criterion for teaching on the course and a faculty policy that enabled staff to contribute over a period and develop consistency of approach. They differed over whether all team members should have a link to clinical practice.
The role was perceived as challenging and importance was attached to support through induction programmes for new team members, ongoing support for the team as a whole, and support for the mentorship programme leaders.

7.8 Preparing sign off mentors for their role

The main focus of this chapter thus far has been the preparation of mentors to facilitate learning and assess competence. The introduction of sign-off mentorship necessitates further preparation of some mentors to fulfil this new role. Sign-off mentors have already been considered in Chapter 5 in relation to the rationale for their introduction and the various processes entailed in ensuring that there are sufficient numbers in post. As an HEI senior educationalist observed, the NMC has no preparation requirements for sign-off mentors other than having to meet the eligibility requirements and undertaking three assessments under the observation of an experienced sign-off mentor. This section considers aspects of the capacity required to provide sign-off mentor preparation (7.8.1); issues raised by the requirement for three assessments of the trainee sign-off mentor undertaking an assessment of student competence (7.8.2); and views about responsibilities for monitoring the quality of preparation (7.8.3).

7.8.1 Format and provision of sign-off mentorship preparation

There were three components to the provision of preparation for the requirements of sign-off mentorship: inclusion of the subject in the mentorship course; subsequent study days/workshops, and three assessments of the trainee sign-off mentor assessing a student’s competence. At the time of fieldwork, there was much discussion about these three assessments as the NMC had recently announced that two of these could be undertaken as simulations and not under observation in practice as hitherto. The simulated assessments were sometimes included in sign-off mentor study days. Participants’ responses focused on the nature of sign-off mentor preparation, their own involvement and views about respective HEI and trust responsibilities for this aspect of mentorship capacity.

Inclusion of sign-off mentorship preparation in the mentorship course

Group A (HEI-1 and trusts 1-3): HEI-1 used to offer a one-day course on sign-off mentorship. At present however, sign-off mentorship was introduced in the mentorship module in the sessions on accountability with reference made to the criteria for becoming a sign-off mentor and consideration of the differences between a mentor and a sign-off mentor. This was essential when course membership included midwives as midwifery mentors are all designated as sign-off mentors.

Group B (HEI-2 and trusts 4-7): Likewise at HEI-2, some reference was made to sign-off mentorship in the mentorship module. The concepts underpinning sign-off mentorship had recently been included in the course, partly in response to HEI participants’ concerns about misunderstanding among trust staff about what sign-off mentorship entailed. At present, after completion of the mentorship course, each mentor was given a mentorship portfolio which included sign-off mentor preparation through study days and opportunities to be assessed on ability to assess a student. Among the Group B participants, however, there was also discussion about including sign-off mentor assessment scenarios in the module in response to the workload that was falling on PEFs to prepare enough sign-off mentors; a point expanded further in the next section.
Study days/workshops for sign-off mentorship preparation

Reference has already been made in Chapter 5, (Section 5.8) to the provision of study days and workshops; this is expanded here with a focus on content and HEI and trust input.

Group A (HEI-1 and trusts 1-3): The Group A participants, both HEI and trust, described their joint approach to study days for mentors who wished to become sign-off mentors. In recognition of the importance of sign-off mentorship to the assessment of students’ fitness for practice, a senior educationalist explained that the HE1 and its trust partners had adopted a joint approach to preparation for the role. The HEI was keen to support the process in its early stages and the trust participants stressed the importance of their own involvement. As a PEF explained, when sign-off mentorship was first introduced trust personnel thought through how they should prepare sign-off mentors not only in terms of the specific NMC standards but also what would be most helpful for sign-off mentors themselves. Trust personnel were concerned to ensure consistency and quality of the preparation.

A working group, comprising HEI and trust representatives, was established and developed a set of materials for developing sign-off mentorship (a workbook, a set of slides, guided studies, sign-off mentor pocket guides and a range of simulation exercises). These were then used in a series of workshops run, in most instances, jointly by link lecturers and PEFs. At the time of fieldwork, HEI personnel felt that a ‘critical mass’ of sign-off mentors had been developed and were in the process of withdrawing from the workshops. These were then run by trust personnel using the same materials. The HEI participants regarded sign-off mentorship preparation as a trust responsibility but continued to support it on the grounds that it was in their best interests to do so. Support took the form of, for example, enabling supervised assessments to take place in the HEI simulation centre.

Group B (HEI-2 and trusts 4-7): A senior educationalist reported that, although the HEI was not directly commissioned by the trusts to provide sign-off mentors workshops, some of the link lecturers were involved in these; a point corroborated by some of the link lecturers. The trust senior educationalists observed that while not aware of the details of sign-off mentor preparation themselves, they were confident that the PEFs were well aware of what was required. The picture that emerged from the PEFs’ accounts was one in which several were finding it hard to find sufficient time to deliver all the preparation that was required and, as a group, had been seeking greater input from the HEI in this respect; the HEI programme leader said that this was under active consideration.

PEFs’ experiences and approaches differed, depending partly on the nature of their trust. Thus the PEF for a primary care trust provided sign-off mentorship preparation when she was undertaking mentor updates and appeared to do so alone. In two trusts, the PEFs held mentor updates in the morning and then sign-off mentor workshops in the afternoon jointly with the link lecturer. For another trust, the PEF described running a half-day study day that incorporated one simulated sign-off assessment but was concerned that once the NMC ruling was implemented that two of the three assessments could be simulated, a whole study day would be required and that resourcing this by PEFs alone would be difficult.

While most of the PEFs in Group B wanted increased input from the HEI in sign-off mentorship preparation, the preferred format differed. So while one PEF argued for a sixth day to be added to
the existing mentorship course to focus on assessment and to include a simulated sign-off assessment, others argued for a stand-alone HEI-based study day on sign-off mentorship for mentors who had been qualified for at least a year. Cost effectiveness was much to the forefront of these participants’ thinking; it was costly for the trusts to give staff time to attend study days - be it a half day in the trust or possibly a full day in the HEI - moreover the latter would also require PEF input as facilitators and as one of them said:

“But it kind of needs to happen, but also with it being as cost effective as we can in the current climate.” (TPEF7)

The requirement that sign-off mentorship preparation had to include three observed assessments of competence had considerable resource implications. The decision that one, and more recently two, of these could be simulated rather than being undertaken in practice meant that these could be included in the course or in study days. As the subject as a whole occasioned considerable comment about robustness and practicality, participants’ views are further expanded in Section 7.8.2

7.8.2 Assessing trainee sign-off mentors’ abilities to assess student competence

When the NMC first introduced sign-off mentorship, they initially allowed healthcare providers to nominate those mentors regarded as sufficiently experienced to take on the role of the sign-off mentor without any additional training. This nominating of mentors was for a preliminary period only, after which time the would-be sign-off mentor had to be supervised undertaking a final destination placement assessment on three occasions. The person observing the assessment and confirming that it was of an appropriate standard had to be a qualified sign-off mentor themselves or hold a qualification regarded as equivalent, such as a community practice teacher. Achieving this required three people to be in the same place at the same time; namely the trainee sign-off mentor, the student being assessed and the person observing the process. This proved difficult to achieve on three occasions for each trainee sign-off mentor and hence the NMC subsequently allowed first one and then two of these three assessments to be undertaken in simulated conditions.

The HEI and trust participants described the situation in the trusts with which they were familiar, which personnel were involved, the challenges of undertaking these in practice, and the benefits and robustness of simulated and actual assessments.

Implementing requirements for assessment of trainee sign-off mentors

Several differences emerged in the issues confronted by the various services included in the project and so these are considered separately.

Primary care trusts: In one of the primary care trusts, two of the three assessments could be simulated whereas the other trust was at the stage of considering whether to introduce them. Participants acknowledged that there was less need for sign-off mentors in community settings as they were less in demand from students for final destination placements but observed that the number needed had nonetheless been difficult to achieve when three observed assessments in practice were required.

The scattered nature of community workplaces meant it could be extremely difficult to get the three people required (the student, the trainee sign-off mentor and the observing sign-off mentor)
together at the same time and the length of time occurring between each assessment sometimes resulted in loss of momentum in ensuring that the three were completed. Participants in the second primary care trust where all assessments were still observed in practice described recruiting a recent tranche as ‘just managing it by the skin of our teeth.’ It was when they were nearing the introduction of the second wave of sign-off mentors that the question of replacing an observed assessment with a simulated assessment had been raised with the HEI. The assessments were undertaken by the link lecturer and not the PEF in the first trust and by both post-holders in the second.

**Hospital trusts:** Two of the three hospital trusts used a combination of simulated and actual assessments; the third had not introduced simulation at the time of fieldwork. Participants (link lecturers and PEFs) relating to the first two trusts spoke of having insufficient personnel to provide simulated assessments in study days given the sheer numbers of trainee sign-off mentors needed in the trust and in one trust, the PEF felt strongly that greater input was needed from the HEI in the provision of simulated assessments. Participants in all three trusts referred to the difficulties of getting the three requisite people together for the observed in practice assessments and in the trust in which all the assessments were undertaken in practice the trust senior educationalist said:

“Well it’s all around time and the pressures operationally and clinically in doing that because there is no extra time allocated extra for that. It all has to be done within clinical time. So it’s the opportunity, it’s taking the opportunity when you can and then it’s having the right people available to do that.” (TSE6)

Some of the PEFs and link lecturers relating to these three trusts were qualified sign-off mentors and so undertook the assessments of trainee sign-off mentors. Others said that that they had no role in this and that personnel such as trust clinical leads were the personnel qualified in this respect. There were some examples of HEI and trust participants working closely together over these assessments; for example one programme director who was a qualified sign-off mentor said that if there were difficulties with the PEF being present at the same time as the trainee sign-off mentor and student, then they would try and cover this on a weekly visit to the practice setting. Looking ahead, an HEI senior educationalist observed that link lecturers and PEFs who were sign-off mentors played an important role in these assessments but that this would decrease as the number of sign-off mentors in the trusts increased and could take over this responsibility.

**Mental health trusts:** Both the mental health trusts used a combination of two simulated assessments and one observed in practice assessment and participants in both said that the introduction of the former had been essential to the feasibility of being able to introduce the second wave of sign-off mentors. As one of the PEFs observed, they had over 100 separate practice settings in the trust and achieving three observed in practice assessments had been very difficult. The study days that included the simulated assessments were undertaken by the PEFs. In one trust, the remaining observed assessment was undertaken by the PEF or a clinical lead/manager but not by the link lecturer who was not a qualified sign-off mentor. In the other trust, the reverse was the case as there were HEI lecturers who were qualified as sign-off mentors but neither of the PEFs were qualified as such. As with the hospital trusts, it was observed that once sufficient staff were
qualified as sign-off mentors, they would be undertaking these assessments rather than the HEI staff.

**Benefits of the two approaches to assessing trainee sign-off mentors**

Some participants offered views on their perceptions of the robustness of the two approaches to assessing the trainee sign-off mentor’s ability to assess student competence. One of the PEFs stressed the importance of retaining one observed assessment in practice:

“It gives you the confidence that there is somebody to fall back on if there is an issue. ‘Am I doing it right?’ Because it is very, very traumatic to fail somebody, it’s not easy. I think it’s very difficult to fail somebody, very emotionally daunting.” (TPEF2)

Simulated assessments were regarded as having the benefit of providing trainee sign-off mentors with the opportunity to meet together at study days that included the simulated scenarios and discuss issues that were common across different practice settings and those that differed and to learn from each others’ views and experiences. Another advantage was having the opportunity to put learning about assessment into practice in a simulated situation and consider the issues it raised before undertaking an actual assessment in practice. A third benefit was that having two simulated assessments meant that the whole process could be achieved in a shorter time than hitherto, given aforementioned difficulties in organising observed assessment in practice, and that this was better for learning:

“I think it’s easier when you are learning something new to actually keep reiterating it and consolidating it in a frequent format.” (TSE2)

Concerns were also raised about the robustness of simulated scenarios in light of knowledge of the very different ways in which these was approached across the country; for example some places used video clips of scenarios with accompanying documentation for the trainee to complete while others used observed role play.

**7.8.3 Responsibilities for the quality of sign-off mentor preparation**

All participants were asked about where responsibility should lie for the quality of sign-off mentor preparation; 11 of the 22 HEI participants and 11 of the 15 trust participants were familiar enough with the situation to provide a response. Three main responses were given as to where responsibility should lie: mainly a trust responsibility; a shared responsibility but with the trust having primary responsibility; and shared jointly between the HEI and the trust. There were some different emphases between groups of participants.

**Trust responsibility – wholly or mainly**

HEI participants were most likely to say that it was a trust responsibility (trust alone (5) or shared but primarily trust (2). These participants thought that the trust was the best place for responsibility to lie as they were providing mentoring for students; trust personnel identified as appropriate for taking this responsibility varied and included PEFs, clinical leads and the sign-off mentors’ line manager. Those who thought responsibility should be shared but with the trust having primary responsibility commented on the nature of HEI input into the process. This input included working with a line manager to support sign-off mentors perceived as not performing to the required
standard and assuring themselves that the mechanisms being used by trusts to monitor quality were appropriate since if the NMC, in the course of a validation visit, found that a trust was not up to standard in this respect ‘the university would be penalised because we hadn’t assured ourselves that it was OK.’

Just over half (6) of the trust participants commenting opted for trust responsibility. These participants thought that personnel appropriate to be involved included the PEF and the sign-off mentor’s line manager and recognised that although responsibility lay with the trust for monitoring quality, the preparation materials had been developed jointly with the HEI.

**Joint responsibility**

Of those HEI participants (4) who saw the quality of sign-off mentor preparation as a joint responsibility, emphasis was placed on the shared nature of the development of the materials that were used for sign-off mentor preparation and assessment. A cautionary note however was sounded by one participant in that this shared responsibility did not become one in which the trust did all the work and then the HEI came in at the last minute and was overly critical.

Trust participants regarding responsibility as joint (5) said that this reflected joint working in developing materials and involvement of both organisations in providing study days and assessing trainee sign-off mentors assessing a student’s competence. One of these participants however, added that it should be joint but at present was mainly shouldered by the trust:

> “We mainly deliver it – they give guidance. It’s not joint at the moment but I think that it should be joint provision with the HEI. I think in lots of ways the HEI do view it as our responsibility to provide sign-off mentor preparation.” (TSE2)

**7.8.4 Key points on sign-off mentor preparation**

- Sign-off mentor preparation took the form of: making reference to it in the mentorship module; study days/workshops, and three assessments of the trainee assessing student competence.

- The move to having one or two of these assessments as simulations was welcomed in light of difficulties in achieving three observed assessments in practice.

- Several benefits of simulated assessments were noted but reference also made to the importance of retaining at least one as ‘observed in practice’.

- HEI and trust personnel both contributed to sign-off mentor preparation with much joint working over, for example, running study days and assessing those assessments based in practice.

- HEI participants were most likely to regard sign-off mentorship preparation as a trust responsibility (wholly or primarily) in the long-term and this view was shared by some but not all of the trust participants some of whom advocated a shared approach.

- Both groups were aware of the resource implications of sign-off mentor preparation and the importance of cost-effective approaches was noted.
7.9 Observations on findings as a whole on educating learner and sign-off mentors

Findings presented in this chapter have focused on capacity to educate learner mentors to facilitate learning and assess student competence and to prepare sign-off mentors to assess students as fit to be placed on the register. The education and preparation of these two groups emerge from the findings as a resource intensive enterprise in which a range of personnel in higher education and healthcare providers engage in a diversity of activities, with concomitant resourcing in terms of time, course fees, hard copy and e-learning materials, and on-line course provision. Participants’ perceptions have revealed ongoing commitment to ensure the quality of educational provision and that several aspects of how it is provided are the subject of debate.

Educational preparation was very much a joint undertaking between HEIs and their healthcare provider partners with evidence of sole and joint working by post-holders in both organisations. The key HEI post-holders were mentorship programme leaders, teachers and those with links to practice, with some overlap in post-holders having more than one of these roles. In delivering the content of the module, course teachers had to meet challenges of: meeting the learning needs of a course membership with very diverse educational backgrounds; ensuring that course content was relevant to learner mentors’ practice environment; addressing anxieties about the assessment component of the mentor’s role, and achieve a balance between creating awareness of the responsibilities of mentoring students at the same time as engendering sufficient confidence to undertake it. Findings that the assessment component of the role of the mentor is the one most likely to cause anxiety reflect those of other studies (e.g. Moseley and Davies, 2008). As link lecturers, HEI personnel provided support for staff in their practice setting who were attending the course and contributed to the provision of sign-off mentor preparation in the form of study days, simulated assessments and, if a qualified sign-off mentor themselves, assessing trainee sign-off mentors.

The key healthcare provider post-holders were mentors acting as supervising mentors (mentor buddies); the role entailed providing guidance and support for learner mentors and verifying their learning achievements. This is a role that has received little attention with the exception of a recent study by MacLaren (2012). Healthcare provider post-holders also included those qualified as sign-off mentors who could contribute to assessments of trainees (PEFs, clinical leads, community practice teachers, and practice setting managers). HEI and trust post-holders worked together in developing course content and materials, monitoring its progress, and running workshops and study days. Post-holders in both types of organisation were involved in supporting learner mentors while on the course and in assessing trainee sign-off mentors.

The main resource for educational preparation was that of staff time (course fees were considered in Chapter 4, Section 4.7.1). The key point about time was that whilst there was clarity over some aspects, for example the amount of time spent leading a programme or teaching a course, time available for other aspects was regarded as not always sufficient and/or was contested as to where responsibilities lay. Examples relating to time included: the extent to which trusts gave staff study leave for on-line learning; whether mentor buddies were able to spend sufficient time with learner mentors given other demands on their time; the potential impact of reducing staff numbers in HEIs on the amount of time link lecturers could give to supporting learner mentors in practice; the impact of staffing mentorship courses on other faculty demands on lecturers’ time; and whether PEFs had sufficient time to prepare staff for sign-off mentorship given the numbers required and competing
demands on their own time. The findings showed that while all aspects of the process of educating mentors were taking place, there was also a sense of ‘push and pull’ over time both within and between the HEIs and trusts in the study.

Other resources included the cost of setting up and supporting on-line provision and the materials and documentation required for the course. The move to on-line provision was seen primarily as a means of reducing the costs of mentorship to healthcare providers but the view that this also reduced costs to HEIs was contested by those supporting learners by means of this mode of delivery.

Turning to the quality of educational preparation, most participants regarded the course as a good or adequate preparation for the role of mentor and several examples given of good practice in sustaining the delivery of mentorship focused on aspects of this course and the preparation of sign-off mentors. Attention was drawn however to aspects of educational preparation that some participants perceived as detracting from its quality and these included variation in the quality of supervision by mentor buddies and in the quality of learning environments. Challenges were noted in ensuring that quality was maintained such as preparing learner mentors for the aspect of the course they found most difficult – namely assessing student competence; and sustaining high quality discussions between learner mentors when studying on-line.

The overall picture was one of substantial resource devoted to ensuring that the preparation of mentors and sign-off mentors was as robust as possible. In considering how preparation might best be taken forward, participants questioned certain aspects of its provision. Questions arose over whether the course was offered at an appropriate level for the diversity of staff required to ensure the availability of mentors in all settings in which students needed to gain experience. There was diversity of view over whether all those teaching mentorship courses should be nurses with a link to clinical practice or whether the inclusion of other expertise was beneficial. There were differing views over whether more sign-off mentorship preparation should be included in the mentorship course or that this should wait until mentors had been qualified for at least a year. There were debates about the level of experience required to assess trainee sign-off mentors and about the appropriateness of including HEI staff in this process in the long-term. There were also debates about the cost-effectiveness of moving to increased on-line provision of the mentorship course.
Chapter 8: Mentorship capacity: Delivery and evaluation

The focus of the previous three chapters has been the capacity to ensure that elements required for mentorship to be delivered are in place; namely sufficient numbers of appropriately prepared mentors and sign-off mentors in environments regarded as suitable learning environments for students. The various roles and resources required to reach this point have been discussed along with considerations of maintaining quality and debates about the future direction of mentorship provision. The question arises as to how this hinterland to mentorship is manifest in the delivery of mentorship in practice. This is the focus of this last chapter of findings in which aspects of delivery are considered along with various mechanisms for its evaluation and participants’ views on its quality.

Programmes to ensure that students are prepared for placements are discussed in Section 8.1 and meeting standards for time to be spent with students in Section 8.2. Support for mentors in practice is the subject of Section 8.3 while Section 8.4 considers ongoing development of mentors through annual updates and triennial reviews. Section 8.5 focuses specifically on participants’ experiences of implementing the NMC standards for mentorship. The next section (8.6) turns to the monitoring and evaluation of mentorship and includes formal mechanisms such as placement audits and the views of participants on the quality of mentorship, in particular the robustness of judgements about competence. Findings as a whole are considered in Section 8.7.

8.1. Preparing students for placements through induction programmes

The roles of some HEI and trust participants included preparing students for practical experience to maximise the likelihood of gaining benefit from it and, in particular, their relationship with their mentor. All those in HEIs with a practice link and senior educationalists were asked about student preparation for practice (6/9 at HEI-1 and 5/9 at HEI-2 were sufficiently involved to respond) as were all the PEFs (8).

8.1.1 Preparation prior to first placement

Participants at both HEIs described a practice preparation programme for first-year students before they started their first placement. In one HEI this took the form of a 35-day induction programme which included periods of attachment to the practice area in which students’ first placement would be based; the programme was provided by link lecturers. The first-year induction programme in the other HEI took the form of a series of presentations about practice education over three months and was provided by a senior educationalist with a remit for practice education. Topics covered in these induction programmes were similar at both HEIs and included: professional practice in terms of behaviour and dress; how to use practice portfolios; the role of mentors; what mentors expected from students and what students could expect from mentors; and how to gain maximum benefit from the experience. Some of this information, along with details of the placement allocations system, was also available on HEI student websites.

Each of the PEFs described the first-year student induction programme that they provided. The programme content was similar across trusts and included:
“And during that we talk about practice learning experiences, different types of experience we have, the level of support they will have and what to expect and then we will deal with their hopes and fears.” (TPEF2)

Other topics included: what the mentor would expect of students; and the importance of letting someone know if, for example, they had not been allocated a mentor by the time the placement started.

8.1.2 Ongoing preparation throughout the course
HEI and trust participants were also engaged in preparing students for subsequent placements. HEI participants prepared students for the particular circumstances of each placement and year, examples included: what to expect in the nursing home component of second-year community placements; preparing third-year students to become mentors themselves by, for example, facilitating learning for more junior students. Students were perceived as often having very high expectations of mentoring in the sense of being with their mentor all the time and HEI participants tried to ensure that preparing students for practice was also ongoing in the trust. In one trust, for example, an induction programme had been introduced for second and third-year students as well as first, as feedback to PEFs from mentors had indicated that students were arriving in the first placement of the year without being clear about trust expectations for that year of the course. A PEF in another trust met with students at the start of their third year and spoke about ‘shifting up a gear this year’ in terms of what the trust expected of third-year students. At all trust induction sessions, the PEFs always stressed to students the importance of getting in touch with them if their mentor was unavailable at the start of the placement or went on sick leave during its course, so that another mentor could be allocated.

8.1.3 Key points on induction programmes for students
- Trust and HEI participants provided induction programmes prior to initial and subsequent placements to facilitate students gaining maximum benefit from the experience.
- Content included expectations of professional behaviour, the mentor-mentee relationship, the type of practical experience likely to be encountered, and informing staff if mentoring arrangements were not in place.

8.2 Meeting NMC standards for time to be spent with students
Two of the NMC standards concern the amount of time that students spend with mentors. Each student should be spending 40% of their time in a placement working with their mentor and the sign-off mentor in final destination placements should spend one hour a week with the student, this is in addition to the student spending 40% of time working with a mentor, who is often but not necessarily the same person as their sign-off mentor. Capacity to meet these standards was explored with participants; all the trust participants responded (15) and 14 of the 22 HEI participants, primarily those with a link to practice.

8.2.1 Students spending 40% of time with mentor
Trust and HEI participants responded as to whether or not they perceived the 40% of time standard as being met and most expanded on the factors that in their view facilitated or hindered its achievement.
Meeting the target
Some participants in both groups observed that it was within the standards that some of the 40% could be spent with a co-mentor or another mentor. All the PEFs reported that, in the main, students were spending 40% of their time in a placement working with their mentor; an observation based on contact with the practice settings and on evaluation mechanisms. Five trust senior educationalists held the same view while the other two were unsure but observed that this would be monitored by the PEF.

“Yeah, I haven’t had any challenges or complaints where the students feel they’re not getting enough, they know exactly what they need to do, don’t let it get worse, talk to your tutor, let’s come together for a meeting, it has been known.” (TSE1)

Two trust senior educationalists said that senior nursing personnel in the trust were constantly stating to the managers of practice settings, the importance of adhering to the 40% standard and that the managers did pay a lot of attention to ensuring that this was the case.

A slightly different picture emerged from the HEI participants who drew on reports from students and from linking with mentors in practice settings. Two thought that the 40% target was always met whereas others responded by focusing on the difficulties in achieving this target and perceived that it was not met for all students. Those involved in the mentorship programme said that time for mentoring was a major preoccupation for learner mentors:

“You are trying to work through ideas with them about how you can support students in a really stressful acute environment where you don’t seem to have the time. Talking through the practicalities and they then are saying things like, ‘yeah but we wouldn’t get any support to do that’ because it’s not seen as a priority.” (HSE2)

For mentors working in particularly busy environments, both HEI and trust participants noted that the targets were sometimes achieved by mentors undertaking some of the associated work in their own time; a situation in nursing perceived as not unique to mentorship by this trust participant:

“So I think they use some of their own time definitely to do that. And I think that’s an expectation for nursing as a whole, for not just this but lots of things – that have built up over the years..... and I think there’s always been a lot of goodwill and that’s how we work as a nursing workforce I think across the NHS.” (TSE5)

Goodwill was also the focus of an observation by an HEI participant who linked with an acute setting:

“So when, and it is goodwill, it is goodwill, what you will find over and over again..... is that mentors will give their own time for students. So they will stay back an hour to do the paperwork, to have the interview [with the student] because there is no time in the day.” (HPL2)

Overall, students were perceived as spending the requisite amount of time working under the supervision of a mentor. In some of the very busy environments, participants observed that the target was hard to meet if staff were unwell for any length of time, as resources were stretched to the limit and there was little flexibility to accommodate adverse events.
Mechanisms for monitoring the target
Most trust participants gave details of mechanisms that monitored the meeting, or otherwise, of the 40% target for each student. These included: off duty rotas which showed the allocation of students to staff on duty; student evaluations of placements; and through regular contact between the PEF and mentors and students. In one trust, the project manager for the new electronic rostering system had built an alert into the system that let PEFs know when students were not spending two shifts a week with their mentor. In two trusts, participants were either unsure or thought that the amount of time was not monitored. These monitoring mechanisms were referred to by some of the HEI participants, who also included reports from their students as sources of information on this topic.

Factors facilitating or hindering meeting the target
Some of the factors perceived by trust and HEI participants as facilitating or hindering the amount of time that students spent with their mentors related to organisational changes, while others focused on actions and priorities of mentors and students themselves.

Organisational changes: Organisational changes regarded as impacting on mentors’ time in primary care trusts included: clinics closing down and students having to help staff pack up and move equipment; district nurses being amalgamated into bigger teams and then overall team numbers being reduced; an increase in the number of healthcare support workers that qualified staff have to supervise; reductions in the numbers of managers, which meant not only fewer people to support mentors but also mentors having to take on more management tasks themselves; increasingly heavy client caseloads; and an increase in the number of mandatory training days which staff had to attend.

In the hospital trusts, increased pressures on time were attributed to increased acuity of patients; higher rates of patient turnover; constant interruptions and no quiet areas in which to meet with students; job freezes and reduction of registered nurse posts; and an increase in the proportion of healthcare support workers compared with registered nurses. An HEI participant with a link to a hospital trust described the staff as ‘being on a shoe string’ and that this had an impact on the quality of mentoring:

“So I just think for some students they miss out on so much. Students who are doing really well, they miss out on so much because they could be pushed further. The students who are borderline and can hide, they miss out on so much because they can be seen as ‘Oh they’re doing okay, they’re doing okay’.” (HPL2)

Helping mentors manage competing priorities: For mentors themselves, attention was drawn to competing priorities of patient care and student nurse education but also to ways in which mentors could be supported in meeting both.

A PEF summed up the competing priorities:

“I think what helps is that 99.9% of mentors are really proud and willing to support students, they love working with students, so that really helps. What hinders is the time element. There is a lot of pressure on the staff in terms of mentoring, but they do work very hard to support students. I
think time is the most expensive resource in the organisation. And for all of us in practice the patient comes first, the patient comes second, the patient comes last, and nothing else exists. So I think we are stretched.” (TEF2)

An HEI participant drew attention to the need to accommodate both:

“Again that’s the real world we are living in and their priorities are to do with the patients. But at the end of the day they also know that they have to prepare our students for the future.” (HPD2)

Various strategies were identified to support mentors in being able to manage the competing demands of patient care and student nurse education. Those involved with the mentorship programme said that being able to deliver patient care at the same time as supporting students was a key theme in the course content. HEI and trust participants referred to encouraging mentors to manage their time through: not regarding mentorship as a separate task from patient care but to be thinking about the students’ learning experience all the time; considering how to involve students when coping with heavy patient workloads; and to regard documenting evidence about student progress and completing the portfolio as part of an ongoing process and not something to be left to the end of the placement.

Other suggestions focused on managing mentoring at a locality level rather than an individual level. Thus an HEI link lecturer argued in favour of a rotation system in which those who had students had a slightly reduced workload; this would then give them the ‘breathing space’ to respond to student questions about why something was done in a certain way, by suggesting that the two of them spend time together researching alternative approaches to the procedure. Another strategy, this time advocated by a PEF, was that the manager of the practice setting needed to take a step back from time to time and consider whether students, at different stages of the course and different levels of ability, were being allocated to the appropriate mentor to ensure resources were being deployed to maximum effect.

**Student contributions to meeting the target:** Mentorship is a two way relationship however, and trust and HEI participants also focused on how students could facilitate the process of ensuring that they spend 40% of their time with a mentor. The observation made most often was that students changed their rota at short notice in order to accommodate their childcare needs; this could negate arrangements made for them and their mentor to be working together. As the following comments show, participants recognised the importance of family-friendly policies but that these had to be balanced with students recognising the difficulties of ensuring that they and their mentor spent sufficient time together.

“As a consumer of flexible working I support it but it’s a nightmare from an organisational point of view of trying to keep our pre-reg students supported.” (MPT1)

“At the moment we are quite strict, although we do say to students we are a family friendly organisation, we do say that this is the working pattern in the organisation and they’re expected to fit in with that.” (TEF7)

At times, students were challenged about the impact on mentorship arrangements of sudden rota changes:
“If they suddenly change their shifts, there’s a lot of shift changing goes on to meet childcare so sometimes you have to catch it on that thing and say ‘Excuse me, we’re making an effort here to meet the standards, why are you changing your shifts?’” (TPEF6)

The other aspect of students’ contribution focused on their approach to their relationship with their mentor. This included learning how to negotiate with their mentor to ensure that their needs could be met and to plan ahead. HEI participants saw it as part of their role to encourage students to have a thoughtful attitude towards their mentor by, for example, not bringing their portfolio in to be signed on the last day of the placement and expect their mentor to stay late to do this:

“Because they have a life outside work just like the student has a life outside of here. And I think sometimes students are very egocentric.” (HPD2)

8.2.2 Sign-off mentors spending an hour a week with final destination students

Meeting the standard of sign-off mentors spending an hour a week with students in final destination placements appeared to be a more challenging target than the 40% of time with a mentor and was of particular concern to some of the trust senior educationalists.

Of the two primary care trusts, participants in one were unsure if the target was met and, as yet, had had very few final destination students; those in the other trust said that sign-off mentors were able to protect the requisite hour each week. For the five trust participants who related to mental health trusts, the two senior educationalists were unsure, although observed that the PEF would know. Of the PEFs, one said that the target could be met while the other two stressed that this was the case, but could only be achieved with considerable difficulty. In the three hospital trusts, meeting the target appeared to be the most challenging. Of the six participants: one did not know as the target had not been monitored as yet, a senior educationalist thought it had been met, while the other four (two senior educationalists and two PEFs) all said that it was not. A senior educationalist made the point thus:

“I can’t say hand on my heart that they are.” (TSE2)

And a PEF from another hospital trust:

“No way do they have the one hour. If staff have the one hour they do it in their own time.” (TPEF5)

It was the acute care patient settings in adult and mental healthcare services that appeared to be particularly challenging environments in which to protect the one hour a week. A senior educationalist attributed difficulties to the influx of new junior people who needed a lot of support and the priority of meeting the needs of patients requiring very high levels of care. Likewise when referring to acute care in mental health:

“That’s very difficult because sometimes you set time aside, you arrange certain times, something happens on the ward and you have to attend to it. And there can be days of very heavy sort of work going on in the clinical area that doesn’t allow you to have time away.” (TPEF8)
The essence of the problem over protecting the hour was perceived as one in which the costs in terms of time were not recognised and built in as such into managers' budgets. And it was this inclusion that was crucial:

“Until it’s factored into a job, into a job plan, it will always be a challenge.” (TSE6)

One trust participant described the situation as one in which trusts should either accept that sign-off mentorship had a cost, and hence build it into their budgets, or be prepared to challenge the NMC over the feasibility of its implementation. For another trust participant, the problem was lack of discussion between the NMC and trusts:

“I can understand why the NMC have done it but they haven’t had any kind of discussion with trusts and how you’re actually going to achieve this. You’ve been told you are going to do it but no one has actually said ‘well this could be almost an impossible task’ and it is an almost impossible task for some areas.” (TSE2)

But for others, it was just something that healthcare providers had to get on with:

“I think the requirements are a challenge but they are our professional body and I think we have to abide by that and we have to fulfil those regulations and use them in a positive way if that is necessary and ensuring that we have the ability and capacity to do so.” (TSE6)

Another perspective on the NMC was that perhaps they could allow trusts more flexibility in deciding how essential the protected hour was in all cases. A PEF in a mental health trust for example, observed that while they would certainly not allow someone onto the register whom they felt was unfit for practice, at the same time it was not always necessary for all third-year students to be spending an hour a week with a sign-off mentor in addition to the 40% of time already spent working under supervision.

The most frequent response among the HEI participants was that as far as they knew, sign-off mentors were able to protect an hour a week to spend with their final destination placement students. A few others observed that they were not sufficiently involved to know. Experiences differed among the link lecturers: some observed that the time was protected within the working week, others (linking with acute areas) that sign-off mentors spent this hour with the student in the former’s own time. One of this group observed that a flexible approach was the key to success in the areas in which they linked with; the sign-off mentor would spend two hours with the student in the weeks when on duty and then not be available in other weeks.

8.2.3 Key points on meeting targets for time spent with students

- The majority of participants perceived that the 40% of time target was met for all or most students.

- The target was achieved with difficulty in very busy clinical environments and could depend on mentors using their own time for aspects of their role.

- A range of mechanisms were available for monitoring that the 40% target was being met.
• Diverse changes to service delivery and organisation impacted on mentors’ capacity to spend time with students.

• Various strategies were deployed to help mentors meet competing priorities of patient care and student nurse education.

• Students could hinder the target being met by sudden changes in the rota to meet childcare needs and by unrealistic expectations of mentors.

• Meeting the one hour protected time target for sign-off mentors appeared to be more challenging than the 40% target and particularly so for trust participants.

• Concerns were expressed that the time was not costed into budgets and that there had been insufficient liaison between trusts and the NMC about the feasibility of the target.

8.3 Supporting mentors in practice

In recognition of the fact that mentoring can be challenging, especially in the early months after completing the course, part of the role of PEFs and link lecturers (a group that in this project included learning community education advisors (LCEAs) is to support the staff working as mentors in the practice areas to which they link. Participants in this study were asked what was entailed in this aspect of their responsibilities; for their views on the significance of these roles for supporting mentorship in practice; and whether they were changing or likely to do so. Sixteen of the twenty two HEI participants provided a response as did thirteen of the fifteen trust participants; these participants included all the HEI link lecturers and all the trust PEFs.

8.3.1 Means of contact and subjects addressed

All participants stressed the importance of the speed with which mentors could get in touch with a link lecturer or a PEF when they needed advice or support. Link lecturers and PEFs could be contacted by phone and email, and administrative systems had been implemented to forward calls to someone else who could help if they were unavailable. Face to face contact took place through drop in surgeries for mentors and students, through pre-arranged one-to-one meetings or on an ad hoc basis when link lecturers or PEFs were visiting their practice areas. The mode of contact, and the question of whether the PEF or the link lecturer was most likely to be contacted first, varied between trusts. Contact details of PEFs and link lecturers were readily available for both mentors and students.

Reference was made to an evaluation of the learning community education advisor role, which showed that mentors particularly appreciated the LCEAs having a dedicated mobile for mentor support. Those participants who linked to a multi-site practice area relied on a mobile to make sure that the speed of response was the same for all sites; with one remarking “the speed of response is, I think, more than excellent.” Contact by phone tended to be used for minor queries and advice and included: information about students and courses; and what needed to be written in the ongoing achievement record.

Drop in surgeries had proved to be welcome and a PEF gave an example of how this addressed an unmet need for mentors in the trust:
“We ran a student surgery once a month and we found that it was always the mentors who came. The students do get a lot of support through the link lecturers and the HEI. It was the mentors that were feeling a little bit left out there so that was quite interesting, so we changed it to a student or mentor surgery so anybody could come along if they had a worry or concern.” (TPEF1)

One of the trust senior educationalists said that the drop in surgery was a good source of support for new mentors and especially for those working in areas where there were not enough experienced mentors to supervise and support them. However, staffing levels could make it difficult for the new mentor to be released to attend the surgery and she emphasised the importance of the PEF’s visits to practice areas to provide support and answer queries. These comments related to acute settings and were echoed by a PEF in another trust, who had found that mentor forums and drop in surgeries did not function well because staff could not be released to attend them and hence her presence on the wards was central to mentors being able to access support.

Face to face meetings were usually requests from mentors for advice and support when they were struggling with students whose performance they perceived as poor; when there were personality clashes between mentors and students; and over having to fail a student.

“Sometimes they are worried about a student’s performance in practice and they ask me to come along and offer advice and I’ll be involved in action planning or something on those lines.” (HPL2)

PEFs and link lecturers observed that they constantly encouraged mentors to ask for help as soon as they felt there was a problem:

“We always tell them at mentor updates and they know from past experience I always say ‘if you can’t deal with something, or you need a bit more support, I can help, and I can get the student to meet me and we can just try and find out what’s happening’. And lots of problems have been resolved in that way.” (TPEF4)

The approach to help varied according to perceived need; it included meeting with various combinations of the mentor, student, link lecturer and PEF; and role-modelling in difficult situations:

“Sometimes I’ve had to role model a difficult conversation, say the things that they’re too scared to say because they’re like ‘I’m actually finding this really difficult to say’ so I role model it. I might take the lead. If the student had been particularly challenging, I might take the lead in the interview to take the pressure off the mentor so that they can concentrate on the answers the student is giving.” (HPL3)

From the perspective of some of the PEFs, particularly those whose practice area covered several sites, the visits to practice also provided an opportunity to provide annual updates for any mentors in the setting for whom it was due.

8.3.2 Visibility in practice: current and changing roles
High visibility of PEFs in practice areas was perceived as beneficial by both trust and HEI participants as this trust senior educationalist confirmed:
“The PEF team are your eyes and ears. You need them to be out there, you need them to be, I personally think very much on the frontline. So out in uniform, working with the students, picking up the feel of the environment, working with the team.” (TSE5)

And a PEF describing her role:

“I suppose it’s being visible and being available really, I think that is one of the big things, not on an email really, it’s just you are always walking around, I’m always around and I think you do need to be because you become familiar and I think that’s how they know you are fair that you’re not going to go in, you’re not a distant figure who comes in when there’s trouble.” (TPEF6)

All observations made by HEI participants on the PEFs’ role were unanimous in their appreciation of the importance of the PEF’s role in supporting mentors and students:

“I would really rate their performance in supporting learning. They do an absolute fantastic job in supporting mentorship students. Because they know their patch, if a mentor goes off sick they will jump in and act as the mentor.” (MPL2)

For some HEI participants, the PEFs role was seen as evidence that responsibility for supporting mentors was best located within trusts but there were already anxieties about the future of the post:

“It could all change if in the greater scheme of things the PEFs start getting culled. That’s a big worry. If the PEFs go or that level goes then I think we would have big problems.” (HPD3)

Concern about the long-term future of PEF posts was heightened partly because the role of link lecturers was undergoing change. Those who held these posts placed a high store on the value of their presence in practice. Being seen in practice settings enabled mentors to feel comfortable in raising concerns with them, provided opportunities to have ad hoc meetings as the need arose and was valued by the clinical staff generally. Recently however, link lecturers from both HEIs had found that the time they could spend in their link area was decreasing, due to reduction in lecturing staff numbers, increased pressure of work in the HEI, and a shifting of emphasis in the priorities of their role. Hence their contribution to supporting learning in practice amount was affected:

“We’ve lost a lot of link lecturers to support the learning community of practice, so we just can’t deliver in the way we used to.” (HPL7)

“We had a really quite defined link role, it was good and we do work very closely with the PEF. But as I’ve said, because there have been pressures on the link role recently, I think that’s affected my ability to go out more and I really do think that’s quite important to maintain those clear links with practice so they feel you are involved with them and vice versa. And I think that needs to be reaffirmed.” (HPL5)

Some trust participants commented on the decrease in link lecturer support and link lecturers were aware themselves that their trust colleagues missed the support, partly because the PEFs perceived that they then had to fill this gap. The question of link lecturer support was the subject of comment by some of the HEI senior educationalists who said that a different approach had to be adopted to
meet changing circumstances and some such initiatives were already in evidence. One of these participants focused on the impact of reduced budgets:

“The system works but it’s going to become again more problematic as budgets get reduced all over the place and I think some of our custom and practice, and expectations on all sides are going to have to be challenged really.” (HSE3)

Two other senior educationalists, one from each HEI, queried whether weekly visits by link lecturers were a good use of academic time in that, when they arrived, the staff might be too busy to talk to them and their students might in fact not be there. Their comments echoed the quotation above in that expectations of mentors, students, and particularly practice setting staff about link lecturer presence would have to be changed. One of these HEI senior educationalists referred to a new, more focused model of support that they were developing which combined visits made only for ‘really good reasons’ with good mobile technology in practice settings so that staff could access help in the expectation of a timely response. A link lecturer in the same HEI described forthcoming meetings about programming in more time in clinical areas with each visit being used for annual updates and, at the same time, providing an opportunity to respond to any current need for support and advice.

The senior educationalist for the other HEI referred to a system which they already had up and running in the independent sector and were considering extending to settings in trusts. This took the form of a link lecturer running a regular series of forums for key mentors which considered the issues that mentors found difficult, and then the key mentors were able to provide support for mentors in their own practice area. A trust senior educationalist who linked with this HEI said that there had been concern about the decrease in link lecturer support and that the system needed to be more robust; they were currently working with the HEI as to how this might be rectified.

The link lecturers who held the learning community education advisor posts did not, at the time of fieldwork, appear to be affected by having to reduce the time spent in practice as this was very much the essence of their remit. In the long term however, there was uncertainty about the sustainability of their roles as there was with the role of PEFs.

8.3.3 Key points on supporting mentors in practice

- Systems were in place that enabled mentors to readily gain advice and support from PEFs and link lecturers.
- Minor queries were dealt with by phone or email, face to face meetings were sought for more complex matters usually relating to student performance or difficult relationships.
- Mentors were encouraged to seek advice as soon as a problem was evident.
- High visibility of PEFs and link lecturers in practice settings were perceived as facilitating the ease with which mentors felt able to raise problems and as being appreciated by other staff in the setting.
The amount of time that link lecturers spent in practice areas was under pressure and regarded by senior HEI personnel as unsustainable; some initiatives were underway to make their input more focused.

Some concern was expressed about long term sustainability of practice based roles of LCEAs and PEFs.

8.4 Professional development for mentors
As Chapter 7 has shown, mentors undertook a course to prepare them for their role which was based in and provided by the HEI, and included periods of practice supervised by trust personnel. Sign-off mentors were also prepared for the additional responsibilities entailed in their role. Learning about mentorship however, was not regarded as a one-off event and the NMC required evidence of ongoing professional development in the form of annual updates for each mentor and, more recently, a triennial review of their progress. Both these forms of continuing professional development required resourcing and participants were asked about responsibilities for providing them and perceptions of capacity to do so.

8.4.1 Annual updates
Aspects of the provision of annual updates included: where and by whom the updates were provided; responsibility for knowing when an update was due; ease with which mentors were able to attend; the content of the update; the format in which it was delivered, and perceptions of the value of the enterprise. All but one of the trust participants knew sufficient to respond (14/15) as did 16 of the 22 HEI participants; the latter included all the link lecturers.

Diversity of provision
There was considerable diversity in the way in which annual updates were provided in terms of both the format and the personnel involved in delivery. Some trusts included annual updates as one of the sessions in the programme for trust-based mandatory training programmes. Updates were also offered as stand alone half-day or full-day workshops on either HEI or, more usually, healthcare provider premises. Thirdly, updates were provided in practice settings, most often to a small group but sometimes on a one-to-one basis when it could be included as part of a meeting already set up at the mentor’s request. This ‘opportunistic’ approach was seen as particularly valuable when mentors were working in small-scale settings where it was difficult to cover their absence at an off-site session. Most trusts offered at least one of the off-site formats, as well as on-site provision, in order to facilitate the likelihood of attendance.

There was also diversity as to who provided annual updates. Thus examples were given of provision by link lecturers alone, by PEFs alone, and by both personnel providing the session jointly. Participants relating to two of the trusts described a series of mentor workshops during the year (8 in one trust and 12 in the other) hosted and provided jointly; in one, overall facilitation was the responsibility of the PEF, in the other it was the link lecturer. Another trust which included annual updates in the twice weekly mandatory training programme had a system whereby the update session was provided alternately by the PEF and the link lecturer. The impact on time could be considerable with examples given of a learning community education advisor providing over 40 in a
year attended by a total of more than 200 mentors, while a PEF reported undertaking two a week in practice settings each taking between two to three hours to deliver.

**Awareness when updates were due and ease of attending**

Perceptions and practice differed over where responsibility lay for mentors knowing that an update was due. For some participants this was a matter for which mentors were responsible themselves; as one observed the need to keep updated was well publicised:

“I think that the message is out there, you can’t escape from it, you’ve got to be updated and you’ve got to attend otherwise you are not live on the register so you are not a mentor and we’re not using you.” (HSE2)

PEFs in one trust said that if they were aware from the register that a mentor had not been updated, they informed the person’s manager and made it clear that if they did not access an update session soon they would be in breach of NMC standards for remaining a mentor, and would be downgraded to co-mentor status. However, in other trusts the PEF sent out reminders to all those on the register when they were due for an update and in another trust the link lecturer reported that this fell within their sphere of responsibility.

There was recognition among participants that, with the best will in the world, working circumstances could prevent a planned attendance at an update session. Examples were given of pressures on managers of busy acute wards:

“As a ward manager you might have all good intentions of sending two of your staff off for the rest of that afternoon [for an updating session] and then all hell breaks loose on the ward and you can’t. And I think that’s difficult.” (HPL6)

For mentors working in small scale settings or working in people’s homes, examples were given of people having booked a place and then finding that they were the only person on duty:

“And often they’ll book a couple of times and then they don’t come, they’ll come the third time. So I’m always very flexible about it because they might turn up for work and there’s nobody else to do the work. Because that happened to me working [as district nurse]” (TPEF4)

Expectations about mentors’ use of their own time differed between trusts, while participants in some saw this as a commitment that should be fitted into the working day, others expected mentors to attend in their own time.

**Content and format of delivery**

In most instances, the content of annual updates described by participants was two-fold: first, provision of information about, for example, changes to the pre-registration curriculum and revisions of NMC policies; and second, opportunities to discuss and share experiences about challenging situations encountered in the course of delivering mentorship. Both aspects were regarded as essential for mentors’ professional development but there was some debate about their suitability for on-line or face to face modes of delivery.
Some participants held the view that updated information for mentors could be provided and accessed on-line and that it was perhaps not the best use of their time, or that of the person providing the update, for this information to be provided in a face to face format. Moreover, it enabled mentors who simply could not find time in their working day, or in their own time to attend a session, to be updated through completion of on-line workbooks which they then discussed with their manager. There was near universal agreement however, among both trust and HEI participants, that the update should ideally include a face to face component as the best way of enabling discussion about mentoring challenges, as the following examples show:

“What the mentors want, if you ask them, is how to use the practice assessment document and how to manage the challenging student. That can only be done through a workshop and discussion, so that’s the preferred method.” (HSE1)

“The disadvantage with online is you’re both working in isolation of each other and that is not a good thing. I think if we want to have a coordinated, collaborative and partnership approach to this, then you must have interaction, physical interaction.” (HPL5)

And a PEF in a trust which was considering some on-line provision for updates:

“But we would still be reluctant to totally replace the face to face workshops because you don’t get the cross fertilisation of ideas.” (TPEF7)

Face to face formats also had the benefit of staff appreciation:

“Oh thank goodness someone has come and given us some time and valued us and said thank you.” (TPEF3)

A couple of participants, while recognising the importance of face to face discussions, thought that these could be provided in practice settings as part of joint reflection sessions with students rather than having to leave the setting for an off-site session.

Some participants referred to the NMC position on having a face to face component to updating and a range of views emerged: some thought that there had to be a face to face component for each mentor every year; others that there had to be a face to face component at least once in every three updates; while others thought that the NMC guidance on the point was unclear.

**Perceived value of annual updates for mentors**

The majority view among trust and HEI participants was that annual updates were a valuable contribution to enhancing the quality of mentorship that mentors were able to deliver. As one trust senior educationalist put it:

“Any opportunity to think through the work you are doing with students can only be valuable.” (TSE5)

There was recognition that for some mentors, the update could become a necessary ‘tick box exercise’ but that for others it was very welcome:
“Six of one, and half a dozen of the other. Some people go because they have to go; some people I know that they’ve turned up twice a year because they can’t wait. They’ve got a burning desire, and they like that opportunity to go and talk to everybody.” (HPL3).

As with perceptions of the adequacy of the mentorship course (Chapter 7, Section 7.6.1), some participants observed that, without a formal evaluation, no conclusions could be drawn about the value of annual updates. And one observed that even if the update was positively evaluated, those providing it were not necessarily in a position to observe if the content had been translated into practice.

8.4.2 Triennial reviews

Triennial reviews comprised each mentor keeping a record of their mentoring activities and their reflections upon the process; this was to be reviewed by a senior colleague once every three years. Although these reviews were at an early stage of implementation in 2011 when the project fieldwork was undertaken, participants were asked about: the means by which they were undertaken; perceptions of their value, and views about where responsibility lay for ensuring that they were completed. Most trust participants (13/15) were sufficiently familiar with the reviews to respond on the subject as were six of the seven HEI link lecturers. Of the other 15 HEI participants, a total of 6 knew sufficient to respond.

In Groups A and B, the HEI and their healthcare provider partner had worked together to develop a portfolio in which mentors could keep a record of their mentoring activities and their reflections upon the various processes that these entailed. The policy adopted in all the trusts in the study was for the mentors’ triennial review record to be discussed in the course of their annual appraisal. It was argued that this was preferable to leaving the review for three years and that it fitted logically into a review of professional development for which a time had already been allocated. While there was near consensus among participants that the annual appraisal was the most appropriate format for reviewing mentoring activities, two caveats were raised. Firstly, appraisals did not have 100% completion record, with figures of 30-60% reported as not being uncommon; hence a mentor could miss out on a review of their mentoring activities. Second, the quality of the review depended on the ability and commitment of the person undertaking the appraisal:

“My view is that they can be very good but again I think it can be dependent on the people that are undertaking it.” (TSE5)

Most participants regarded the introduction of the triennial review positively for two reasons. Firstly, it provided an opportunity to reflect on and discuss mentoring, as summarised by this participant:

“I think they’re quite important...because it enables you to reflect on where you are, what issues you have, what is impacting on enabling you to become or to be as effective as you would like to be as a mentor and how you might be able to address it. So I think it’s quite an integral part of the whole mentorship delivery programme.” (HPL5)
Secondly, the review provided evidence of whether each mentor had met the NMC standard of mentoring at least two students within each three year period and hence was seen as a measure of the use, or underuse, of mentorship capacity:

“It’s all very well that they have been prepared as mentors but they may sit back and not do anything at all. It can happen for three years, especially when they move jobs and they don’t mentor. So they’ve never kept the momentum as working as a mentor for students even though they have been prepared for it, so I think it’s a good way of monitoring.” (HPD1)

In this regard, an HEI senior educationalist provided an example of a practice setting with over 20 mentors but in which only two or three students a year had been placed. Although this might provide a rationale for removing the status of mentor from staff who had not met the NMC standard for whatever reason, be this organisational or individual, this action might hinder the person’s career progression if they were no longer on the mentor register. The link with promotion was thus at odds with ensuring that capacity was appropriate.

Most participants seemed clear that ensuring triennial reviews were completed was a trust responsibility. Trust participants described the work in progress to ensure systems were in place; a task that had proved quite challenging for some:

“And it’s something that we haven’t completely cracked and it’s something we are making progress on, but it’s something that we’re finding really difficult. I take my hat off to organisations that aren’t [finding it difficult].” (TSE5)

The fact that completion of triennial reviews was a benchmark in NMC validation visits to HEIs, caused some of the HEI participants in this study to express concern that they might be criticised for failure over a matter that they had no authority to enforce.

8.4.3 Key points on professional development for mentors

- Annual updates for mentors included both receipt of information and opportunities for discussing challenging aspects of mentoring.
- The updates were delivered in a diversity of formats by PEFs and/or link lecturers; time commitments to do so could be considerable.
- Mentors could encounter difficulties in finding requisite time for attendance and trusts differed over whether this should take place in work, or personal time.
- There was agreement that face to face provision better enabled discussion about mentoring but that on-line delivery was appropriate for providing information.
- Annual updates were regarded as a valuable form of continuing professional development for mentors, although some observed that there was no evidence to this effect.
- Triennial reviews were also regarded as a valuable means of professional development and also as a measure of use of mentorship capacity.
There was agreement that responsibility for triennial reviews lay with trusts, whereas annual updates were more likely to be seen as a shared responsibility.

8.5 Implementing the NMC standards for mentorship

Throughout the course of discussing the specific aspects of mentorship capacity reference has been made to many aspects of the NMC 2008 standards for mentorship. Given the centrality of the NMC standards to the delivery of mentorship, perceptions of the implications of the NMC standards as a whole were explored. Responses were given by 16 of the 22 HEI participants and 11 of the trust participants; some made observations about the standards as a whole and others commented in relation to specific standards.

Commitment in theory to the standards

Both HEI and trust participants thought that while the standards were a good idea in theory, many commented that implementing them was often very challenging. In the words of an HEI senior educationalist:

“I really understand where the NMC is coming from and I think that the practice side of education is really important. There’s no doubt that the trusts are signed up. I think somehow we’ve just got to move to a more realistic model because I think the current model is just not fit for practice anymore.” (HSE3)

And two of the PEFs:

“It’s a good idea in theory but it’s quite idealistic in the current climate, the practicalities of it are really difficult to achieve.” (TPEF4)

“The framework I thoroughly agree with. The actual implementation, practically, is impossible.” (TPEF5)

Specific difficulties were highlighted in relation to: students spending 40% of their time working under supervision; the protected one-hour a week for sign-off mentorship not being costed into trust budgets; and staff struggling to find time to attend annual updates and prepare for triennial reviews. Previous sections in this chapter have shown that these targets were perceived as having been achieved although often with considerable difficulty and by staff contributing their own time to the enterprise.

Implementing standards in trusts

Acknowledgement was made by HEI participants of the resourcing implications for trusts. An HEI senior educationalist observed that trusts that had met all the requirements had expended a huge amount of resource in doing so and, in particular, the time of practice and administrative staff. Some of the HEI link lecturers observed trusts had no extra resources to meet the cost of implementing the standards and that these had to come from existing budgets. Meeting the NMC requirements in large trusts was specifically commented on as problematic to achieve. Thus one PEF maintained that a separate post was required just to monitor implementation while another focused on the mentor register:
“The size of an organisation we are of maintaining the NMC register to the amount of data that the NMC require is a massive challenge, an absolutely enormous challenge. And getting information back from some of the services is an absolute nightmare and an extreme challenge.” (TPEF3).

Consistency and flexibility of the standards
Views over the clarity or otherwise of the standards has already been discussed in the context of sign-off mentorship (Chapter 5, Section 5.6) and annual updates (Section 8.4). Some of the HEI participants made general observations that the standards seemed very interpretational in that when they asked the NMC for clarification, replies were inconsistent over time. From the PEFs’ perspective, some of the standards were perceived to be somewhat rigid and could not be adapted to specific circumstances; thus one queried the need for all third year students to spend an hour a week with a sign-off mentor in addition to the time spent with their mentor, while at a broader level another argued that students should spend less time in clinical practice but that the time that was spent would be of a higher quality as pressure would be reduced on mentors.

8.6 Monitoring and evaluating mentorship
Considerable attention was devoted to monitoring the quality of practical experience and, in particular, the quality of mentorship provided. Participants were asked about the mechanisms by which this was undertaken and for their own perceptions of the quality of the mentorship delivered. Most of the HEI participants (19/22) and trust participants (13/15) responded, and this included all the HEI link lecturers and all the trust PEFs. Monitoring was achieved through student evaluations of each placement (8.6.1), the regular audit of each placement as required by the NMC (8.6.2), and a diversity of other mechanisms (8.6.3). The section concludes with participants’ perceptions of the contribution of mentorship to student preparation for registration and the soundness of judgements about competence (8.6.4)

8.6.1 Student evaluations of placements
The evaluation questionnaires that students completed at the end of each placement were regarded by all participants as a valuable indicator of placement quality. The questionnaires were collated by the HEI and then fed back to trust personnel and to the HEI lecturer linking with the area. Positive evaluation was important for mentors:

“On the positive side of that, the areas where the students have had really good placements, and making sure again that the staff know about that and it gives them a boost and it helps the students that are following. That’s part of the quality thing.” (TPEF1)

Most of the observations made by participants referred to their value in flagging up problems that needed resolving:

“The students are a very good litmus test for the quality of what is happening on wards. If they indicate that things don’t seen right ....And it’s a real warning sign that something needs to be looked at closely.” (TPEF7)

On receipt of evaluations suggesting that a practice area might be struggling, the PEF and link lecturer would visit the area and, in conjunction with a senior member of the practice staff, develop
an action plan to address the problem. Some trust participants expressed concern that it was often many months after the questionnaires were completed before the collated outcome was received by the trust, thus occasioning delay in getting an action plan in place should one be indicated.

8.6.2 Educational audits of placements

The audit process
At the time of the fieldwork, a move from a yearly audit with a six month review was in the process of changing to a two yearly audit with a one year review. Participants identified a long list of criteria that had to be assessed by means of an audit document regarded in the main as extremely time consuming to complete. There was some discussion as to whether it might be preferable to include several practice areas in the same audit; on the other hand conducting an audit of each setting was seen as the best way of ‘drilling down’ to the detail that was needed in order to ascertain what was happening and then work with the manager of the setting to make improvements if these were indicated.

As with the student evaluations, an action plan was drawn up and progress reviewed at regular intervals. In some instances the audit indicated that, for one reason or another, the environment in the setting was not conducive to student learning and consideration given as to whether the setting should be removed from the placement circuit. As shown in Chapter 6 (Section 6.6.2) every effort was made to work with the staff to avoid this outcome given the importance of preserving as many placements as possible at a time when finding enough placements to accommodate student numbers was often difficult.

Responsibility for undertaking the audit
There were some different emphases in participants’ responses over the question of where responsibility lay for undertaking these audits and following through with an action plan. In the main, participants regarded the audit as a joint HEI and trust responsibility and most accounts described a representative from both sides, most often the PEF and the link lecturer, undertaking the task in collaboration.

Some participants, both HEI and trust, thought that responsibility lay primarily with the HEI. Several of the PEFs who thought that the audits should be a joint responsibility were finding increasingly that they were undertaking the bulk of the work entailed:

“It’s a joint responsibility with the HEI and does come within the link lecturer’s remit. But I very much drive it and pull it all together and pull in everyone as much as I can – I tend to be the link person.” (TPEF4)

For another PEF, the increasing shift toward the trust undertaking more of the work involved in the audit, was an outcome of the reduction in numbers of lecturers. The audits had been undertaken by the HEI staff at one time but they became unable to manage the paperwork with a reduced team. Since the areas could not be left unaudited if they were to remain on the placement circuit, the PEFs had taken on the auditing. This participant went on to say that a recent statement by the strategic health authority had indicated that audits were the responsibility of the PEFs but the HEI’s responsibility to make sure that they were completed.
As with other aspects of ensuring that mentorship capacity was sufficient, there seemed to be some lack of clarity as to where responsibility lay.

### 8.6.3 Other means of monitoring practical experience

Other means of monitoring practical experience included reviews of the Practice Assessment Documents with a focus on the details of the written assessment made by the mentor. Reference was made to two aspects of these which merited being discussed with the mentor: firstly if the assessment given seemed inconsistent with the student’s progress thus far and secondly if the feedback to the student was not very informative:

> “If there are mentors who only write a one liner, I go back to them and say ‘another time it might be useful to be a bit more constructive so that they know how to develop’.” (HPD2)

Link lecturers’ and PEFs’ knowledge of the strengths and weaknesses of the mentors in their practice areas was also a valuable means of monitoring the quality of mentorship. Providing annual updates and regular visits to practice areas also provided opportunities to become aware of factors that might be adversely affecting quality of delivery. Other mentors would also be aware of problems:

> “To be blunt if someone is not pulling their weight with a student then their colleagues will know.” (TSE3)

### 8.6.4 Perceptions of the quality of mentorship

All participants regarded mentorship as essential to the preparation of nurses with some observing that there was no unequivocal evidence to this effect. Qualifying statements about the contribution that mentorship made included: dependence on the aptitude and willingness of the student; the experience and commitment of the mentor; and the extent to which the practice environment was conducive to student learning. Observations were made that mentorship was particularly important for supporting students who were regarded as ‘borderline’. Several participants thought that ‘mentorship did the best with what it had’ and returned to views reported earlier about new approaches to delivering mentorship in the future; in particular whether all nurses should be mentors (Chapter 5, Section 5.5.4) and new models for allocating students to practice settings (Chapter 6, Section 6.6.3).

Participants were also asked about the confidence that they had in the judgements that mentors made about students’ competence. The majority said that they were confident in mentors’ assessments and this view was expressed with greater confidence in relation to the judgements made by sign-off mentors. Additional observations included that there was no unequivocal way of knowing but that the quality of newly qualified nurses would not suggest that there was a major problem in this respect.

Several trust and HEI participants identified factors that they perceived as potentially limiting the soundness of assessment of competence in practice. These included: difficulties in getting to know students when placements were short; workloads that precluded sufficient time to make assessments; and less robust governance procedures for the clinical components of the pre-registration programme compared with the academic components. This latter point focused on judgements in practice being made by a single individual whereas those in the HEI were the outcome
of a system in which several individuals were involved in the assessment of each student through a system of marking, moderating and assessment boards.

8.6.5 Key points on monitoring quality of mentoring

- A diversity of formal and informal mechanisms were deployed in monitoring the quality of mentorship provided during students’ placements, some of which were perceived as resource intensive activities.
- Student evaluations of placements provided an early warning of potential problems.
- Diversity of view existed over where responsibility lay for undertaking regular placement audits, although was most likely to be regarded as a joint HEI/trust responsibility.
- Local knowledge of practice settings and informal contact were also sources of monitoring.
- Action plans were put in place to manage and resolve problems and progress reviewed regularly.
- Every attempt was made to support placements perceived as failing due to concern over loss of an increasingly scarce resource.
- Participants spoke positively about the contribution of mentorship to student preparation and, in the main, had confidence in the judgements that were made about competence.

8.7 Overview observations on the delivery and evaluation of mentorship

Practice-based post holders in trusts and HEI lecturers with a link to practice were involved in a diverse range of activities in supporting the delivery of mentorship in practice. These activities included: providing induction programmes for pre-registration students prior to placement experience; supporting mentors through electronic means and face to face meetings; managing student expectations of mentorship; providing mentors with annual updates and helping them to prepare for triennial reviews; monitoring the quality of mentoring through various mechanisms including placement audits; and developing and reviewing action plans for practice areas encountering problems over mentoring. The PEFs and the link lecturers observed that their high visibility in practice settings was appreciated by students, mentors and other staff in the setting, as was a rapid response to requests for help via phone and email. The programme directors, mentorship programme leaders and the HEI and trust senior educationalists all regarded the introduction of the post of PEF as a key factor in facilitating student nurse learning. Similar findings have been reported for other studies that have included PEFs (Clarke et al 2003, Larsen et al 2006, Jowett and McMullan 2007, Carlisle et al 2009).

Many examples were given of trust and HEI personnel sharing responsibility for aspects of delivering and evaluating mentorship in practice. These included providing annual updates for mentors in various formats and in undertaking the regular audit of placements that were required by the NMC. The role of the link lecturer was seen to be changing in that they were less able to spend as much time in practice as hitherto and this was already having an impact in that PEFs were taking on a greater proportion of tasks that were previously shared. HEI senior educationalists were advocating a different approach to the deployment of lecturing staff in practice. The decrease in time spent in
practice by link lecturers has been noted in other studies but whereas some of these reported an overlap between the role of the PEF and the link lecturer (e.g. Clarke et al 2003), the picture that emerged here was one of collaborative working, with each contributing the perspective of their own organisation. The role of learning community education advisor had been introduced as an alternative means of ensuring an HEI presence in practice; however the long-term sustainability of these posts was not guaranteed.

The delivery of mentorship in practice was subject to a range of quality assurance procedures. There was support for the approach that the NMC had taken over, for example, ensuring that students were working under supervision for 40% of the time they spent in practice and for the one hour protected time a week for sign-off mentors. However, there were difficulties in ensuring that these were implemented, particularly in busy acute care settings where there was little flexibility to accommodate sudden changes such as staff sickness. Other aspects of the NMC standards occasioning comment focused on perceptions that the policies were not always consistent and some were unduly rigid. In addition to the placement audits required by the NMC, HEIs and trusts worked collaboratively on a range of mechanisms to monitor the quality of mentorship: student evaluations; reviews of Practice Assessment Documents, and regular, informal contact with mentors and students.

Debate centred over whether trusts had and/or should have additional resources to accommodate the extra demands on staff time that meeting the standards required; whether staff should be expected to contribute their own time to required activities such as attending an annual update; and the wisdom or otherwise of providing all aspects of annual updates in on-line formats.

The focus of the project was the capacity in the hinterland that supports the delivery of mentorship and not on the quality of the delivery itself. Given that the delivery of mentorship is the outcome of all the resource that has been expended on bringing the mentor and the student together in an appropriate learning environment, participants were asked for their perceptions of its quality. In the main, perceptions were positive both of the support that students receive from mentors in practice and the soundness of judgements that are made by mentors about students’ competence to practise. A range of qualifying observations were made that for some participants were linked to their views about rethinking the way in which mentorship is currently provided.
Chapter 9: Discussion, conclusions and implications

In exploring capacity to sustain and manage the delivery of student nurse mentorship, this project has provided detailed findings on the complex network of roles, resources, and relationships upon which it depends. Findings have also shown how a focus on quality assurance, and in particular the NMC standards for mentorship, are central to the various activities entailed in: providing appropriate placements; ensuring sufficient numbers of mentors and sign-off mentors; the educational preparation of mentors and sign-off mentors; and the delivery of mentorship in practice. In this final chapter, findings are drawn together and their implications discussed both for the current provision of mentorship, and how it might best be taken forwards in the future.

Strengths and limitations of the study are reviewed in Section 9.1. Participants’ perceptions of what has been achieved in enabling mentorship to be delivered are considered as a whole in Section 9.2 and the challenges that this has presented are discussed in Section 9.3. The focus throughout these two sections is the way in which various roles and responsibilities have been deployed, the resources that this has entailed and the standards to which post-holders have aspired. Several aspects of these achievements and challenges emerge as the subject of debate and, in particular, over how mentorship might best be provided in the future. These are presented in Section 9.4, together with the implications of the various positions that have been advocated. The chapter concludes with recommendations as to next steps (Section 9.5).

9.1 Strengths and limitations of the study

The project was similar in design to many of the earlier studies reviewed in Chapter 2, in that interviews were held with a purposive sample of people with diverse remits for mentorship drawn from higher education institutions and from some of the healthcare providers with whom they linked for purposes of nurse education. Chapter 3 provided a detailed account of how issues of validity and reliability were addressed throughout the design and conduct of the study and the position adopted on generalisability (Section 3.7).

Much of the research on mentorship reviewed in Chapter 2 has focused on specific aspects of mentorship as indicated by the six broad groups into which the reviewed studies were assigned. This project took a different approach in that rather than investigating an aspect of mentorship in depth, a more broad brush approach was taken in order to illuminate the diverse but interlinked aspects of mentorship capacity that underpin delivery in practice. A strength of the study was the demonstration of the diversity of roles, responsibilities and processes entailed in the hinterland that enables mentorship to be delivered; namely providing placements, mentors and sign-off mentors; preparing mentors and sign-off mentors for their role; and supporting mentors in practice. This approach also meant however, that the depth in which each of these roles and aspects of capacity could be explored was limited.

By including higher education institutions and trusts in the study, it was possible to explore both sides of the partnership working regarded as essential to the provision of mentorship and to illuminate the benefits and challenges that this can present. The inclusion of diverse settings and services in the trust sample meant that the findings were not location bound, but the independent sector was not represented other than in the experience of lecturers who linked with this sector. Although a wide range of people with very diverse remits for mentorship were included, the
diversity of titles in use may have meant that there were others whom we did not include but who may have offered different perspectives on the subject.

Participants regarded the content of the interview schedule as relevant to their own situation and, in the main, were willing to talk at length about the subject. This reflected thorough pilot work; interview guides designed to achieve a balance between structure to aid comparison and openness to allow new topics to emerge; and understanding, as far as possible, the role of each person in their organisation prior to the interview to ensure that the right question was asked when there were options. Although every attempt was made to ensure that all topics were covered, there were occasions when one or two were omitted; hence the indication in most sections as to how many participants provided a response.

A rigorous and well documented approach was adopted for the analysis which drew on procedures recommended by key authors in the field of policy focused research. The aim in the analysis and presentation was to show the range of views and experience of the subject under consideration and the various factors perceived as influencing them. Readers are therefore able to assess the transferability of the findings to their own circumstances and although this study was undertaken in London, these are likely to find resonance elsewhere.

9.2 Mentorship capacity: achievements
In considering achievements in relation to capacity for delivering mentorship, this first section focuses on the specific remits that were achieved (9.2.1); the factors perceived as enabling this to be the case (9.2.2); and perceptions of the outcomes of mentorship (9.2.3).

9.2.1 Achieving remits for enabling mentorship to be delivered
Finding showed that, in the main, participants perceived remits as being fulfilled in that there were enough mentors and sign-off mentors in practice areas regarded as suitable learning environments and that throughout the pre-registration programme, students were provided with the requisite practical experience. Mentors were provided with an educational preparation regarded as good or adequate and the needs of different groups were met by offering the course in diverse formats and additional assistance with study skills. Support was in evidence for learner mentors during the course and for the course teachers. Qualified mentors were professionally updated, and sign-off mentors had been selected, prepared and were operational. Delivery in practice was, in the main, meeting the NMC standards and mentors were being supported in achieving this.

Achieving these various remits entailed a diverse range of resource intensive processes and activities. Getting mentors to the point of being in a practice setting with the requisite skills entailed: assessing current numbers and likely future numbers in each practice setting; decisions about continuing professional development budgets for the setting; commissioning places on the mentorship course; adjusting the number of course places available to meet demand; decision-making about which staff should attend the course; and maintaining the mentor register of those who had successfully completed the course. Ensuring there were sufficient numbers of sign-off mentors in final destination placements entailed: assessing numbers needed currently and in the future; informing diverse personnel about the sign-off mentorship policy and its requirements; and preparing trainee sign-off mentors.
Ensuring that throughout their programme each student was placed with a mentor or sign-off mentor in a practice setting that contributed to the overall requisite practical component of their education entailed: HEI and trust personnel always looking out for possible areas for placements; auditing their suitability as learning environments; striving to retain existing placements when concerns arose over quality; accessing information to inform decisions about how many students could be supported; negotiating with practice staff over how many they were willing to support; encouraging people to become mentors; and deciding which student should be allocated to which mentor.

Educational preparation and development for mentors also entailed a range of processes and activities. HEIs made decisions about how and by whom mentorship courses should be provided; course curricula were developed and monitored; study days held; on-line course provision was set up, maintained and supported by course staff; additional support was provided for those requiring assistance with study skills; assignments were assessed; and support was provided for course teachers themselves, especially when first appointed. In practice settings, learner mentors were supported and supervised by qualified mentors (mentor buddies) and verification provided of their practical mentoring activities. Ongoing development and monitoring of mentors took place through annual updates, triennial reviews and from the presence of PEFs and link lecturers in practice areas. Workshops and study days were held for trainee sign-off mentors and arrangements made for them to be assessed, on three occasions, undertaking the assessment of a student, either in practice or through means of a simulation.

Facilitating delivery of mentorship in practice entailed: induction programmes to prepare students for what to expect during periods of practical experience; and providing support for mentors with a range of minor queries; meeting mentoring challenges such as failing students and unrealistic student expectations and resolving difficult interpersonal relationships. Auditing placement quality entailed accessing diverse sources of information; completing a range of documents; and evaluating whether any actions were needed to improve the quality of the learning environment. Preparation was also required in the form of documentation and presentations when the NMC reviewed the provision of mentorship as a whole.

9.2.2 Enabling remits for mentorship to be achieved
Partnership working and a range of resources were seen as the keys to enabling HEI and trust personnel to achieve their various remits in relation to mentorship.

Partnership working
Enabling mentorship to be delivered in practice was the outcome of partnership working between HEIs and the healthcare providers with whom they linked for purposes of nurse education and the provision of a range of financial and other resources. The hallmark of this partnership was multi-stranded working relationships between diverse personnel whose brief included a remit for mentorship, albeit with varying degrees of centrality.

Trust senior educationalists were regarded, in the main, as having overall responsibility for maintaining sufficient numbers of mentors and sign-off mentors but PEFs in particular were key to this happening in practice through assessing capacity; developing close working relationships with practitioners; and maintaining registers. HEI personnel also played an essential part; those with
practice links were key to knowledge of practice circumstances and implications for mentorship capacity; and the course itself was provided by HEI personnel who might have to respond quickly to changing demands for places. PEFs and link lecturers worked together to assess and maintain mentor numbers; trust and HEI staff negotiated over commissioned places and ensured that these were all taken up.

Many of the processes entailed in ensuring that students were allocated to practice settings required a series of negotiations between personnel at all levels in both organisations before a successful outcome could be achieved. Local knowledge of the nature of practice areas, of staff circumstances, of organisational changes affecting the setting, and of needs of particular students were seen to be essential in informing decisions about the number of students that could be supported. It was people based in, or having close links with, practice (the PEFs and the HEI link lecturers) that provided this locally based information.

This detailed knowledge of practice settings combined with creativity, flexibility and willingness to respond to changing circumstances, and channels for regular communication between all parties, were regarded as the essential characteristics of the success of partnership working; they were the ‘glue that held the system together.’

**Resources**

As well as working relationships between and within HEIs and trusts, a range of other resources were also identified as essential to the delivery of mentorship. In HEIs and trusts, a considerable amount of resource was expended in terms of funding and staff time in developing websites and materials to support the different stages of mentorship – from taking the course through to preparing for triennial reviews – and also made the material much more readily accessible. The overall aim was to enhance the quality of mentorship through providing timely information for students and staff and in clarifying, standardising and streamlining the various documents. The outcomes of these endeavours were reported as receiving positive endorsement from mentors and from the NMC in the course of validation visits and were often cited by participants as examples of good practice. The fact that many of the materials were produced jointly by HEI and trust staff working together was regarded as central to the way in which they were well received.

A major resource was the time necessitated in all the processes and activities described in Section 9.2.1 and in building and sustaining good working relationships. Participants raised the question of whether this time was costed and the feasibility, or otherwise, of doing so. Some costs were known and budgeted for, such as course fees (albeit that there was uncertainty and inconsistency among participants themselves on this point). Resourcing mentorship included the time and expertise of staff in practice, other than the mentors themselves, and these included the mentor who supervised the learner mentors; and the sign-off mentors who assessed the trainee sign-off mentor’s ability to assess student competence. Participants also drew attention to the costs of providing cover for those staff who were given study leave to attend the mentorship course; and to their perceptions that mentors and sign-off mentors were sometimes only able to fulfil their remit by using their own time.
9.2.3 Perceptions of the outcome of enabling mentorship to be delivered in practice

Findings showed the complex processes that lay behind enabling mentorship to be delivered in practice and the partnership working and resourcing that these required. The findings also provided an indication of how participants perceived the outcome of this ‘hinterland to mentorship’ in terms of meeting the NMC standards and preparing students to be competent practitioners.

Mentorship was perceived as making a positive contribution to student preparation and competence, albeit that some participants observed that there was no unequivocal evidence to this effect. By and large, mentors were regarded as ‘doing a good job’ often in challenging circumstances. As to whether mentors’ and sign-off mentors’ judgements about student competence was sound, participants also observed that there was no unequivocal way of knowing but that the quality of newly qualified nurses would not suggest a major problem in this respect.

The view was held by most participants that as many processes and systems as possible had been put in place to ensure that mentors and sign-off mentors were able to fulfil their remit. The time and effort expended on the mentorship course was perceived as having a positive outcome in preparing mentors for their role although, as with mentoring students, some participants observed that there was no unequivocal evidence to this effect.

9.3 Mentorship capacity: challenges

The findings showed that participants perceived that the hinterland to mentorship enabled its delivery in practice. At the same time, however, findings showed that participants perceived many aspects of the hinterland as currently construed, as presenting considerable challenges to the way in which mentorship was delivered. Moreover, further challenges were emerging in the current climate of increasing financial pressures in both HEIs and healthcare organisations, changes in service delivery, and changing priorities in the roles of some HEI staff. These challenges are discussed as follows: changing environments (9.3.1); respective responsibilities of HEIs and trusts for mentorship (9.3.2); sustaining posts with a practice education remit (9.2.3); challenges in providing education for mentors (9.3.4); feasibility of meeting expectations of mentorship capacity (9.3.5); and robustness of assessment measures used in practice (9.3.6).

9.3.1 Changing environments

A complex and changing picture emerged from accounts of links between higher education institutions and healthcare providers, and changes in service delivery and organisation. Mergers between trusts and the gain or loss of contracts to provide pre-registration nurse education offered both new opportunities for practical experience for students but also the potential to disrupt long established and productive relationships. For example, a group of organisations that had worked together to standardise a set of documents were sometimes facing being split up, and some then being linked up with other organisations using a different set. Those in HEIs responsible for allocating students to placements were already finding that they were, or soon would be, in competition with other HEIs for the same placements.

Placement provision and the extent to which practice staff felt able to continue with existing agreements about student numbers was affected by re-tendering for service provision; reconfiguration of service delivery; and, in some instances, reduction in the number of registered nurses, for example when teams merged and then the overall number of nurses was reduced.
Wards being moved, and the profile of teams changing, meant that managers of practice settings felt the need at times, to ask for a reduction in student numbers until they were familiar with a new working environment or a new team structure had had time to become established.

Policies of increasing the provision of care nearer home had been reflected in the curriculum for pre-registration nurse education but had not always been accompanied by a concomitant increase in the number of mentors to meet the demand for student places. The use of the independent sector in affording students with practical experience was growing. It was seen as a positive move from the perspective of student nurse education and for the sector itself in opportunities for linking with an HEI. Nursing homes, in particular, were perceived as needing a considerable degree of support in developing mentors and sign-off mentors and this was a challenging commitment for HEI lecturers linking with the sector especially as it comprised numerous small settings spread over a wide geographical area.

While it was acknowledged that changes in service delivery and organisation has long been the background in which mentorship has been delivered, the pace of current and anticipated changes was regarded as particularly challenging.

9.3.2 Respective responsibilities of HEIs and trusts for mentorship

As observed in Section 9.2.1, partnership working between trust and HEI personnel with diverse remits for mentorship ensured its delivery in practice. One of the challenges of this partnership working was the diversity of aspects of mentorship that it comprised and how the division of responsibility for each aspect was allocated. In the main, participants were in agreement as to whether responsibility for each aspect lay with the trust, with the HEI or was a joint responsibility. Both groups were in agreement that responsibility for finding placements lay with everyone involved in pre-registration nurse education. Most were in agreement that responsibility for ensuring that there were enough mentors lay with the trust, as did deciding how many students a practice setting could support and providing mentors with their triennial review. The majority of HEI and trust participants thought that providing annual updates was a shared responsibility.

Nearly all trust and most HEI participants saw maintaining the mentor register as a trust responsibility, while some HEI participants regarded this as a shared responsibility. Likewise with ensuring that there were enough sign-off mentors, most trust participants saw this as trust responsibility whereas most of their HEI counterparts regarded this as a joint responsibility. HEI participants were most likely to regard sign-off mentorship preparation as a trust responsibility (wholly or primarily) in the long term and this view was shared by some but not all the trust participants, some of whom thought this should be a shared responsibility and that the HEI should currently have a greater input.

A source of challenge for HEI participants over respective responsibilities was that the NMC held them responsible for ensuring certain procedures had been achieved that were in fact regarded as a trust responsibility; ensuring that the mentor register was up to date; making sure triennial reviews had been completed; and ensuring that there were enough sign-off mentors were all mentioned in this respect.
9.3.3 Sustaining posts with a practice education remit

Findings have shown that posts which were based in or closely linked with practice were essential to all aspects of the delivery of mentorship. Moreover, the high visibility of PEFs and link lecturers were perceived as facilitating the ease with which mentors felt able to raise problems. HEIs and trusts both faced challenges over these posts in the competing demands on post-holders time and questions over the sustainability of practice-based or linked posts.

There was unanimity of view that the introduction of the role of PEFs had been extremely valuable; a view that had been reported in other studies that had focused specifically on this role (Chapter 2. Section 2.7.2). PEFs’ descriptions of their role indicated that the breadth of their remit meant that they often had competing demands on their time and that these could be exacerbated by ‘fire-fighting’ to deal with changing circumstances. Concerns were expressed about sustained funding for initiatives that led to the introduction of practice education facilitator posts. Similar findings were reported from other studies of practice-based support roles (Clarke et al 2003, Carlisle et al 2009).

Conflicting demands on time were becoming increasingly acute for some of the link lecturers. For the link lecturers themselves, being able to spend less time in practice settings was a matter of regret and a challenge for trust staff who perceived themselves as having to fill this gap. Some of the HEI senior educationalists however, regarded the present system of link lecturer support for practice as unsustainable and that different approaches to ensure support would have to be adopted. One of the HEIs had responded to the need for a consistent HEI presence in practice with the introduction of learning community education adviser posts; however, sustaining the funding for these was also seen as a challenge. Other studies have highlighted the tensions in the link lecturer’s role (Chapter 2, Section 2.7.1); some of these studies also found an overlap between the role of link lecturer and PEF although this was not found in the study reported here.

9.3.4 Challenges in providing education for mentors

Providing educational preparation for mentors was not without its challenges. In relation to the course itself, then those involved in its delivery spoke of having to meet the needs of people with very diverse educational backgrounds, varying levels of familiarity with writing academic assignments and differing levels of competence in working on-line. There was also the challenge of increasing a commitment to student nurse education among those who had taken the course for purely collateral reasons of promotion and meeting organisational needs. The component of the course concerned with assessment of student competence was the one about which learner mentors felt most anxious and the teachers had to achieve a balance between learners having the confidence to assess student competence and at the same time recognising the level of responsibility and accountability that this entailed. In this respect, findings are similar to those of other studies that have shown anxiety amongst mentors is highest about this aspect of their role (e.g. Bray and Nettleton 2007, Nettleton and Bray 2008 in Chapter 2, Section 2.5).

From the perspective of trusts, releasing staff to attend the course was costly and the increase in on-line provision was seen partly as a response to lessen this burden. While this was seen as important in enabling some people to take the course who otherwise might not have been able to do so, it was perceived as challenging in some respects. Firstly, some participants had found that trusts had not given staff the full study leave for the on-line learning days of the course on the grounds that this
could be fitted into their own time; however the view was held that to gain maximum benefit from the course, staff needed dedicated time to study on-line rather than try and fit this in after work or around other commitments. Secondly, while on-line provision was regarded as an effective means of providing information, face to face learning was regarded as a much better format for discussing difficult situations facing mentors, in that learners were able to share experiences and the teacher could facilitate discussion. On-line discussions were seen as much less effective in this respect. The same argument was adduced in relation to annual updates; on-line formats were suitable for updating mentors with, for example, new policies and changes in the curriculum, but were less satisfactory for enabling mentors to share concerns about mentoring.

9.3.5 Feasibility of meeting expectations of mentorship capacity

Those delivering mentorship in practice were expected to be able to provide capacity for the numbers of students commissioned by the Strategic Health Authority and to meet the standards for mentorship set out by the NMC. While both of these were perceived as being achieved, both nonetheless presented a number of challenges.

Student numbers matching capacity

The commissioning process was perceived by some of the HEI and trust senior educationalists as creating difficulties from the outset over the sources of information upon which decisions about the number of students was based, in particular the perceived lack of input by those in the trust who were most in touch with current circumstances and hence the numbers that could realistically be accommodated. Problems were more marked in the hospital and primary care trusts than in the mental health trusts. Although participants reported that they were eventually able to allocate all the students, this often occasioned detailed and ongoing negotiations with practice staff and considerable difficulty and time to resolve. It was outwith the remit of this project to comment on the extent to which the commissioning process did match student numbers with placement capacity but rather to observe that for some participants the outcome appeared to be challenging. Other studies have revealed a mismatch between demand and capacity (Chapter 2, Section 2.8.2) although these also focused on a mismatch between capacity as revealed in placement audits and actual capacity as perceived by practice-based staff.

Meeting quality assurance standards

Ensuring the quality of mentorship provision ran through participants’ accounts of their responsibilities and activities and these entailed multiple mechanisms and safeguards to ensure adherence to NMC standards. At the same time implementing and sustaining all the NMC requirements was challenging and particularly so in current financial, professional and organisational climates.

With regard to the feasibility of implementing the NMC standards, the one hour a week protected time for students to spend with their sign-off mentor was of particular concern to trust participants. This was reported as not having been costed into budgets for practice settings that were final destination placements and proved particularly challenging to meet in acute care patient settings in adult and mental healthcare services. It was in these settings that sign-off mentors were likely to spend an hour of their own time with the student.
The NMC standards for mentorship are revised from time to time and new standards introduced. Time is required to inform people of these changes and the implications that these have for their own practice in relation to mentorship. Findings showed that HEI and trust participants had spent considerable time informing colleagues of the policy to introduce sign-off mentorship through articles, meetings, newsletters and road shows. Recent months had also seen revisions to policies about replacing observed assessments in practice with simulated assessments for trainee sign-off mentors, and the frequency with which annual updates had to include a face to face component, both of which required disseminating to colleagues for whom these changes had implications.

Findings also showed that some policies were perceived as being unclear as to exactly what was required. It was outwith the remit of this research to comment over whether specific policies were clear or not, but to report that some participants thought that they were not. In short, while participants emphasised their commitment to delivering high quality mentorship, meeting the NMC standards in this respect could be challenging.

9.3.6 Robustness of assessment measures used in practice
A challenge that was highlighted by some HEI participants and a few trust participants were differences that they perceived between the robustness of governance measures in higher education to assess students and those in use in clinical practice. In essence, the HEI system was described as involving several different people assessing work through a system of marking, moderating, external examiners and assessment boards; a process that was perceived as robust. The challenge was to have a similarly robust system of assessment in clinical practice where, at present, decisions were made by a single person: the mentor assessing the pre-registration student; the sign-off mentor assessing the final destination placement student; the supervising mentor assessing the learner mentor; and the qualified sign-off mentor assessing the trainee sign-off mentor. The people making the assessment in each case could have very differing levels of experience. The lack of research in this area has been highlighted by MacLaren (2012) in a study of the development of mentors in their practice setting. Some of the HEI and trust participants perceived the quality of these assessments to be variable and while various systems had been developed to standardise the way in which they were made and thus ‘iron out’ variability, this, in turn, could result in a ‘tick box’ approach rather than an assessment of the quality of the learning that had taken place. Looking ahead, it was argued that the challenge lay in developing governance systems for assessments made in practice that were different from, but equally robust as, those undertaken in higher education.

9.4 Mentorship capacity: debating and deciding on future directions
Findings showed that participants perceived that there were considerable achievements in enabling mentorship to be delivered. At the same time, this delivery was confronted with a variety of challenges and a sense had been conveyed that in some respects the system was under pressure, heightened by a rapidly changing climate in terms of re-organisation of service delivery, changes to the pre-registration curriculum and financial constraints. These pressures, combined with some participants’ views that it was time to rethink the way in which mentorship was provided, led to identification of various debates about its resourcing and structure in the future. It was outwith the remit of this project to recommend one course of action rather than the other in these various
debates but rather to explicate these in the context of participants’ perceptions of the implications of different options.

9.4.1 Resourcing mentorship and responsibilities for its delivery

The findings showed that that preparing the next generation of nurses is perceived as a complex matter involving diverse personnel in higher education institutions and healthcare care providers with interlinked responsibilities for many aspects of the hinterland that supports the delivery of mentorship. Preparing the next generation of nurses is resource intensive and while findings showed that participants accepted the need for cost effective approaches to the delivery of mentorship, they also indicated that ways in which this might be approached are the subject of debate.

Deciding where specific responsibilities lie for mentorship

The major resource in enabling mentorship to be delivered is staff time and there were aspects of delivery for which some HEI participants thought that trust personnel should take greater responsibility and some trust participants thought likewise in relation to HEI personnel. Disparate views need debating and reconciling, especially at a time of financial pressures on both organisations, when the likelihood of people holding the view that the other organisation should take more responsibility is likely to increase.

Resourcing practice focused posts

Given the centrality to mentorship delivery of posts with a link to practice in HEIs and trusts, debate and decision is needed on how best to resource this in the future. The key post-holder in the trusts is the PEF and findings have shown how integral this role is to so many aspects of mentorship delivery. The loss of these posts would remove a vital cog in the wheel and the question of sustained funding for PEF posts and by whom needs to be addressed.

The HEI link lecturer’s role was under pressure in its current form and other research (e.g. Clarke et al 2003) has raised the question of whether the role of the PEF might displace that of the link lecturer. Findings from this study, however, suggested that link lecturers had a vital role in practice in their own right but also a role that worked in conjunction with that of the PEF over sharing information needed to make decisions and joint working in providing education and support for mentors. Questions arise therefore as to how this role should develop in the future and that if it is to have a more limited role in practice, whether this needs to be counterbalanced by resourcing HEI posts with a remit that is practice focused, such as that of the learning community education advisors (included in this project as part of the link lecturers group of participants).

On-line versus face to face provision for educational preparation

While it was accepted that providing courses in on-line formats either wholly or partly was cheaper for healthcare providers, there was debate about the cost effectiveness of this option for HEIs. It was felt that the set-up and maintenance costs had been under estimated as had the time required for course teachers to support learners on-line, in particular facilitating discussions on the more challenging aspects of mentorship.
Implications of implementing the NMC standards

While no-one was advocating a dilution of the standard of the quality of mentorship to be provided, findings suggested that the view was held among both HEI and trust participants that consideration is perhaps merited, of the feasibility of all the standards in their current form, and the implications for staff time of implementing the revisions to which the standards are sometimes subject.

9.4.2 Future directions for mentorship

A set of linked debates emerged from participants’ views about who should be mentors and the future shape of practical experience for students.

In the first instance, diverse views were held about whether all nurses should be mentors (the generic position) or whether mentorship should be seen as a role to be taken on by some but not all nurses (the specialist position). Both views were represented among trust participants and among HEI participants. Those favouring the generic position regarded mentoring students as integral to the role of the nurse and one which every nurse should accept as part of their professional responsibilities. The generic position was also regarded as the only means of providing sufficient mentors to meet student demand. In several trusts, the ‘all nurses should be mentors’ system that currently prevails was linked to promotion prospects.

In considering alternatives to the current system, there was recognition in the main that a split between facilitating learning and assessing competence was not desirable and little desire was expressed for a return to the role of clinical assessors. A system was advocated by some participants, whereby a group of mentors who facilitated student learning linked with a senior mentor who made assessment decisions that drew on mentors’ feedback about students’ progress. It was argued that this would address concerns that assessment required substantial experience and the senior mentor would in effect be a sign-off mentor. This approach would offer a career pathway for mentors and senior mentors.

Suggestions were put forward as how a group of mentors linked with a senior mentor might ‘map’ onto different approaches to placement provision; in particular the hub and spoke model which would enable a senior mentor based in a hub a longer period of time over which to get to know a student and thus be in a better position to make an informed decision about their progress. Some participants reported involvement in some early piloting of hub and spoke models.

These different positions raise a series of linked questions:

- Is the education of student nurses best served by a system in which all nurses are mentors or should the role be taken up as discrete career pathway by fewer nurses who have more dedicated time to spend with students?
- Can the mentoring needs of the numbers of students in practice settings be met by fewer mentors each spending more time with students or do student numbers preclude this option?
- How might the different approaches that have been advocated mesh with diverse practice settings and services and with the independent sector?
• What would be the implications for providing educational preparation for the role of mentors and senior mentors if the specialist, rather than the generic position, was adopted?

• Can mentorship be decoupled from a system in which it is the gateway to career progress?

• Is there a means by which relative costs of different models can be assessed?

9.5. Next steps
This project did not lead to a specific set of recommendations for practice or for further research. Rather the project identified the challenges that mentorship faces, in terms of the capacity in the hinterland that supports it and the debates that need to be addressed in considering how it might best develop in the future. We recommend that these challenges and debates be the subject of widespread discussion among those in higher education and healthcare organisations with a remit and a responsibility for the provision and quality of pre-registration student nurse education, in conjunction with professional nursing organisations and the profession’s statutory body, the Nursing and Midwifery Council. That such discussions should commence with some urgency has been highlighted by the recent publication of the Willis Commission report on the future of nursing education which draws attention to the crucial role of mentors in the education that student nurses receive and the training and support that mentors require to fulfil this role (Willis Commission Report 2012).
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